TEXAS MEDICAID
Clinical Edit Prior Authorization
vosoritide (VOXZOGO)

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING	
Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:

STEP 2: CLINICAL PRIOR AUTHORIZATION CRITERIA

☐ Indicate Primary Diagnosis: _____ ICD 10 Code: _____

1. Does the client have diagnosis of achondroplasia confirmed with genetic testing? [Manual Step]

   ☐ Yes (Go to #2) ☐ No (Deny)

2. Is this a renewal request?

   ☐ Yes (Go to #4) ☐ No (Go to #3)

3. Is the client greater than or equal to (≥) 5 years of age?

   ☐ Yes (Go to #4) ☐ No (Deny)

4. Does the client have open epiphyses? [Manual Step]

   ☐ Yes (Go to #5) ☐ No (Deny)

5. Does the client have an annualized growth velocity (AGV) greater than or equal to (≥) 1.5 cm/year? [Manual Step]

   ☐ Yes (Go to #6) ☐ No (Deny)

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6. Does the client have an estimated glomerular filtration rate (eGFR) less than (<) 60 mL/min/1.73m2 (chronic kidney disease [CKD] stages 3, 4 and 5)?

☐ Yes (Deny) ☐ No (Approve – 365 days)

STEP 3: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: **855-668-8553**

Prescriber Signature: _____ **Date:** _____

If criteria not met, submit chart documentation with form citing complex medical circumstances.

For questions, please call Navitus Customer Care at 1-877-908-6023.