TEXAS MEDICAID
Clinical Edit Prior Authorization
voxelotor (OXBRYTA)

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

1. Is the client greater than or equal to (≥) 12 years of age?

   ☐ Yes (Go to #2) ☐ No (Deny)

2. Does the client have a diagnosis of sickle cell disease in the last 730 days?

   ☐ Yes (Go to #3) ☐ No (Deny)

3. Does the client have a diagnosis of severe hepatic impairment in the last 365 days?

   ☐ Yes (Go to #7) ☐ No (Go to #4)

4. Does the client have a claim for a CYP3A4 substrate with a narrow therapeutic index (NTI) in the last 45 days?

   Examples include AFINITOR, sirolimus (RAPAMUNE), tacrolimus (ASTAGRAF XL, ENVARSUS XR, PROGRAF), and ZORTRESS.

   ☐ Yes (Deny) ☐ No (Go to #5)

5. Does the client have a claim for a strong or moderate CYP3A4 inducer in the last 45 days?

   Examples include APTIOM, ATRIPLA, bexarotene (TARGRETIN), bosentan (TRACLEER), BUPAP, butalbital/acetaminophen/caffeine (ESGIC, FIORICET, ZEBUTAL), butalbital/acetaminophen/caffeine/codeine, butalbital/aspirin/caffeine (FIORINAL), butalbital compound-codeine, carbamazepine (CARBATROL, EPITOL, EQUETRO, TEGRETOL), dexamethasone, efavirenz (SUSTIVA), INTELENCE, LYSODREN, modafinil (PROVIGIL), ORILISSA, ORKAMBI, phenobarbital, phenytoin (DILANTIN, PHENYTEK), PRIFTIN, primidone (MYSOLINE), rifabutin (MYCOBUTIN), RIFAMATE, rifampin (RIFADIN), RIFATER, SYMFI, TAFINLAR, and XTANDI.

   ☐ Yes (Go to #9) ☐ No (Go to #6)

6. Does the client have a claim for a strong CYP3A4 inhibitor or fluconazole in the last 45 days?

   Examples include atazanavir sulfate (REYATAZ), clarithromycin, CRIXIVAN, EVOTAZ, flucanozole, GENVOYA, INVIRASE, itraconazole (SPORANOX, TOLSURA), KALETRA, ketoconazole, KORLYM, lansoprazole/amoxicillin/clarithromycin, nefazodone, NOXAFIL, OMECLAMOX-PAK, PREZCOBIX, PREZISTA, ritonavir (NORVIR), STRIBILD, SYMTUZA, TYBOST, voriconazole (VFEND), VIEKIRA, VIRACEPT, and ZYDELIG.

   ☐ Yes (Go to #7) ☐ No (Go to #8)

7. Is the requested quantity greater than (>) 2 tablets daily?

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

8. Is the requested quantity greater than (>) 3 tablets daily?

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

9. Is the requested quantity greater than (>) 5 tablets daily?

   ☐ 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.