



Fax completed form to Navitus at: 855-668-8553
For questions, please call: 877-908-6023

TEXAS MEDICAID

Drug Prior Authorization

Multiple Sclerosis (MS) Agents: ponesimod (PONVORY)

Request Information (required)

This request is:

- Expedited* (Urgent)**
 Standard (Non-Urgent)

*Expedited means the standard review time may seriously harm the member's life, health, or ability to regain maximum function.

Member Information (required)

Prescriber Information (required)

Member Name:			Prescriber Name:		
Member Insurance ID #:			NPI # :		Specialty:
Date of Birth:			Office Phone:		
Member Phone:			Office Fax:		
Member Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:

Please fill out the following information:

1. Medication Requested (Name):
(Go to #2)

2. Quantity Requested:
(Go to #3)

3. Dose Requested (Strength):
(Go to #4)

4. Dosing Instructions:
(Go to #5)

Required Criteria

5. Provide primary diagnosis including ICD-10 code(s):
(Go to #6)

Clinical Criteria (required)

6. Is the member greater than or equal to (\geq) 18 years of age?

Yes
(Go to #7)

No (Deny)
(Go to #7)

7. Does the member have a diagnosis of multiple sclerosis (MS) in the last 730 days?

Yes

(Go to #8)

No (Deny)

(Go to #8)

8. Does the member have a diagnosis of moderate to severe hepatic impairment (Child-Pugh class B and C) in the last 365 days?

Yes (Deny)

(Go to #9)

No

(Go to #9)

9. Is the medication being prescribed concurrently with other disease modifying therapies for MS?

Examples of disease modifying therapies for MS include: AUBAGIO, AVONEX, BAFIERTAM DR, BETASERON, dimethyl fumarate (TECFIDERA), EXTAVIA, GILENYA, glatiramer & glatopa (COPAXONE), KESIMPTA, MAYZENT, mitoxantrone, PLEGRIDY, PONVORY, REBIF, VUMERITY, and ZEPOSIA.

Yes (Deny)

(Go to #10)

No

(Go to #10)

10. Does the member have a diagnosis of myocardial infarction (MI), unstable angina, stroke, transient ischemic attack (TIA), decompensated heart failure requiring hospitalization or Class III/IV heart failure in the last 180 days?

Yes (Deny)

(Go to #11)

No

(Go to #11)

11. Does the member have a history of Mobitz type II second-degree, third-degree atrioventricular (AV) block, sick sinus syndrome or sino-atrial block (unless the member has a functioning pacemaker) in the last 180 days?

Yes (Deny)
(Go to #12)

No
(Go to #12)

12. Is the requested dose less than or equal to (\leq) one (1) capsule/day?

Yes (Approve - 365 days)
(Go to #13)

No (Deny)
(Go to #13)

Additional Information

13. Please provide any additional information we should consider (or attach any supporting documents):
(END)

Submission Information (required)

Prescriber Signature: _____ Date: _____

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

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