

TEXAS MEDICAID

Clinical Edit Prior Authorization etanercept (ENBREL)

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 a diagnosis of Rheumatoid Arthritis, Ankylosing Spondylitis and/or Psoriatic Arthritis in the last 730 days?
 Yes (Go to #4) No (Go to #2)

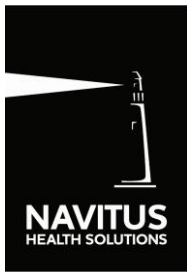
2. Does the client have a diagnosis of Plaque Psoriasis in the last 730 days?
 Yes (Go to #5) No (Go to #3)

3. Does the client have a diagnosis of Polyarticular Juvenile Idiopathic Arthritis (PJIA) in the last 730 days?
 Yes (Go to #6) No (Deny)

4. Is the client greater than or equal to (≥) 18 years of age?
 Yes (Go to #7) No (Deny)

5. Is the client greater than or equal to (≥) 4 years of age?
 Yes (Go to #7) No (Deny)

6. Is the client greater than or equal to (≥) 2 years of age?
 Yes (Go to #7) No (Deny)



7. Does the client have a history of heart failure in the last 365 days? <input type="checkbox"/> Yes (Deny) <input type="checkbox"/> No (Go to #8)
8. Does the client have a history of demyelinating disease (multiple sclerosis, optic neuritis and/or Guillain-Barre syndrome) in the last 365 days? <input type="checkbox"/> Yes (Deny) <input type="checkbox"/> No (Go to #9)
9. Does the client have a history of hematologic abnormalities such as aplastic anemia, pancytopenia, thrombocytopenia, neutropenia, or decreased white blood cell counts in the last 180 days? <input type="checkbox"/> Yes (Deny) <input type="checkbox"/> No (Go to #10)
10. Does the client have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days? <input type="checkbox"/> Yes (Deny) <input type="checkbox"/> No (Go to #11)
11. Does the client have one (1) claim for a contraindicated drug in the last 30 days? Contraindicated drugs include cyclophosphamide, KINERET, and ORENCIA. <input type="checkbox"/> Yes (Deny) <input type="checkbox"/> 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.