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

**TEXAS MEDICAID**

# Drug Prior Authorization
# Enzymes: idursulfase (ELAPRASE)

| Request Information (required) |
|---|
| This request is:<br>☐ **Expedited* (Urgent)**<br>☐ **Standard (Non-Urgent)**<br>*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):
   ****Must be filled by Cook Children's Home Health Pharmacy (Phone: 682-303- 2230, Fax: 682-885 -2499)**

   (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. Does the member have a diagnosis of mucopolysaccharidosis II (Hunter syndrome) in the past 730 days?

- ◯ Yes (Approve - 365 days)
(Go to #7)
- ◯ No (Deny)
(Go to #7)

## Additional Information

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

**Submission Information (required)**

**Prescriber Signature:** _____ **Date:** _____

**** PLEASE FAX COMPLETED FORM TO: 855-668-8553 ****

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