



# TEXAS MEDICAID Clinical Edit Prior Authorization Enzymes

## 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: MEDICATION INFORMATION

Medication Requested (Name):	Quantity Requested:
Dose Requested:	Dosing Instructions:

## STEP 3: CLINICAL PRIOR AUTHORIZATION CRITERIA

Indicate Primary Diagnosis: \_\_\_\_\_ ICD 10 Code: \_\_\_\_\_

1. Please indicate the medication that is being requested:

- Iaronidase [ALDURAZYME] (Go to #2)
- protein C concentrate (human) [CEPROTIN] (Go to #3)
- idursulfase [ELAPRASE] (Go to #4)
- agalsidase beta [FABRAZYME] (Go to #5)
- alglucosidase alfa [LUMIZYME] (Go to #7)
- galsulfase [NAGLAZYME] (Go to #8)
- nitisinone [NITYR / ORFADIN] (Go to #10)
- elapegamase-lmr [REVCOVI] (Go to #11)
- elosulfase alfa [VIMIZIM] (Go to #13)



2. Does the client have a diagnosis of mucopolysaccharidosis I (also called MPS I and/or Hurler-Scheie syndrome) in the past 730 days? <input type="checkbox"/> Yes (Approve – 365 days) <input type="checkbox"/> No (Deny)
3. Does the client have a diagnosis of severe congenital protein C deficiency in the past 730 days? <input type="checkbox"/> Yes (Approve – 365 days) <input type="checkbox"/> No (Deny)
4. Does the client have a diagnosis of mucopolysaccharidosis II (Hunter syndrome) in the past 730 days? <input type="checkbox"/> Yes (Approve – 365 days) <input type="checkbox"/> No (Deny)
5. Is the client less than (<) 2 years of age? <input type="checkbox"/> Yes (Deny) <input type="checkbox"/> No (Go to #6)
6. Does the client have a diagnosis of Fabry disease in the past 730 days? <input type="checkbox"/> Yes (Approve – 365 days) <input type="checkbox"/> No (Deny)
7. Does the client have a diagnosis of Pompe disease in the past 730 days? <input type="checkbox"/> Yes (Approve – 365 days) <input type="checkbox"/> No (Deny)
8. Is the client less than (<) 5 years of age? <input type="checkbox"/> Yes (Deny) <input type="checkbox"/> No (Go to #9)
9. Does the client have a diagnosis of mucopolysaccharidosis VI (MPS VI, Maroteaux-Lamy syndrome) in the past 730 days? <input type="checkbox"/> Yes (Approve – 365 days) <input type="checkbox"/> No (Deny)
10. Does the client have a diagnosis of hereditary tyrosinemia type 1 (HT-1) in the past 730 days? <input type="checkbox"/> Yes (Approve – 365 days) <input type="checkbox"/> No (Deny)
11. Does the client have a diagnosis of adenosine deaminase severe combined immunodeficiency disease (ADA-SCID) in the last 730 days? <input type="checkbox"/> Yes (Go to #12) <input type="checkbox"/> No (Deny)
12. Does the client have a diagnosis of thrombocytopenia in the last 365 days? <input type="checkbox"/> Yes (Deny) <input type="checkbox"/> No (Approve – 365 days)



13. Is the client greater than or equal to ( $\geq$ ) 5 years of age?

Yes (Go to #14)

No (Deny)

14. Does the client have a diagnosis of mucopolysaccharidosis IVA (also called Morquio A syndrome) in the past 730 days?

Yes (Approve – 365 days)

No (Deny)

**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.