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: fingolimod (TASCENSO) ODT

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 this a renewal request (at least 30 days of therapy found in the last 60 days)?

- ◯ Yes (Approve - 365 days)
(Go to #14)
- ◯ No
(Go to #7)

7. Is the member greater than or equal to (≥) 10 years of age?

- ◯ Yes
  (Go to #8)
- ◯ No (Deny)
  (Go to #8)

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

- ◯ Yes
  (Go to #9)
- ◯ No (Deny)
  (Go to #9)

9. Is the medication being prescribed concurrently with other fingolimod products (e.g. fingolimod (GILENYA) capsules)?

- ◯ 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 [Manual]) in the last 180 days?

- ◯ Yes (Deny)
  (Go to #12)
- ◯ No
  (Go to #12)

12. Does the member have a history of therapy with Class Ia or Class III anti-arrhythmic drugs in the last 90 days?

Examples include: amiodarone (PACERONE), disopyramide (NORPACE), dofetilide (TIKOSYN), dronedarone (MULTAQ), quinidine, and sotalol (SORINE/SOTYLIZE).

- ◯ Yes (Deny)
  (Go to #13)
- ◯ No
  (Go to #13)

13. Is the requested dose less than or equal to (≤) one (1) tablet/day?

- ◯ Yes (Approve - 365 days)
  (Go to #14)
- ◯ No (Deny)
  (Go to #14)

Additional Information

14. 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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