



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

**TEXAS MEDICAID**

**Drug Prior Authorization**  
**Enzymes: elosulfase alfa (VIMIZIM)**

**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:

- 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. Is the member greater than or equal to ( $\geq$ ) five (5) years of age?

Yes  
(Go to #7)

No (Deny)  
(Go to #7)

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

Yes (Approve - 365 days)  
(Go to #8)

No (Deny)  
(Go to #8)

**Additional Information**

8. 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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