TEXAS MEDICAID
Clinical Edit Prior Authorization
inotersen (TEGSEDI)

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: COMPLETE REQUIRED CRITERIA

☐ Indicate Primary Diagnosis: _____ ICD 10 Code: _____

1. Is the medication being prescribed by, or in consultation with, a Neurologist or provider that specializes in the treatment of transthyretin-mediated amyloidosis? [Manual Step]

   ☐ Yes (Go to #2) ☐ No (Deny)

2. Is the client greater than or equal to (≥) 18 years of age?

   ☐ Yes (Go to #3) ☐ No (Deny)

3. Does the client have a diagnosis of polyneuropathy of hereditary transthyretin-mediated amyloidosis in the last 730 days?

   ☐ Yes (Go to #4) ☐ No (Deny)

4. Is the client's platelet count greater than or equal to (≥) 100 X 10^9/L? [Manual Step]

   ☐ Yes (Go to #5) ☐ No (Deny)

5. Is the client's urine protein to creatinine ration (UPCR) less than (<) 1000mg/g? [Manual Step]

   ☐ Yes (Go to #6) ☐ No (Deny)

6. Is the requested quantity less than or equal to (≤) the recommended dosing guidelines?

   Recommended dosage is 1 syringe subcutaneous (SQ) weekly

   ☐ Yes (Go to #7) ☐ No (Deny)

7. Will the client have concurrent therapy with patisiran (ONPATTRO) or tafamidis (VYNDAMAX/ VYNDAQEL)?

   ☐ Yes (Deny) ☐ 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.