



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 client greater than or equal to (\geq) 18 years of age?
 Yes (Go to #2) No (Deny)

2. Does the client have a diagnosis of polyneuropathy of hereditary transthyretin-mediated amyloidosis in the last 730 days?
 Yes (Go to #3) No (Deny)

3. Is the client's platelet count greater than or equal to (\geq) 100 X 10⁹/L? [Manual Step]
 Yes (Go to #4) No (Deny)

4. Is the client's urine protein to creatinine ratio (UPCR) less than ($<$) 1000mg/g? [Manual Step]
 Yes (Go to #5) No (Deny)

5. Is the requested quantity less than or equal to (\leq) the recommended dosing guidelines?
Recommended dosage is 1 syringe subcutaneous (SQ) weekly
 Yes (Go to #6) No (Deny)



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6. 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.