



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

TEXAS MEDICAID

Drug Prior Authorization

Cytokine & CAM Antagonists: satralizumab-mwge (ENSPRYNG)

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)

6. Please indicate the requested drug's formulary status: *(Formulary available at www.txvendordrug.com)

Non-Preferred Drug (NPD or NAP)

(Go to #7)

Preferred Drug (PDL)

(Go to #10)

No Status, Drug is not in a Market Basket

(Go to #10)

N/A as this request is for a CHIP/PERINATE member

(Go to #10)

Required Criteria

7. Has the member failed a 30-day treatment trial with at least one (1) preferred agent in the last 180 days?

Yes

(Go to #10)

No

(Go to #8)

8. Is there a documented allergy or contraindication to preferred agents in this class?

Yes

(Go to #10)

No

(Go to #9)

9. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?

Yes

(Go to #10)

No (Deny)

(Go to #10)

Required Criteria

10. Is the member greater than or equal to (\geq) 18 years of age?

Yes

(Go to #11)

No (Deny)

(Go to #11)

11. Does the member have a diagnosis of neuromyelitis optica spectrum disorder (NOSD) in the last 730 days?

Yes

(Go to #12)

No (Deny)

(Go to #12)

12. Will the member have concurrent therapy with a contraindicated drug?

Examples of contraindicated drugs include: ACTEMRA, AUBAGIO, AVONEX, BAFIERTAM, BETASERON, glatiramer acetate (COPAXONE, GLATOPA), dimethyl fumarate (TECFIDERA), EXTAVIA, GILENYA, KESIMPTA, KEVZARA, MAYZENT, mitoxantrone, PLEGRIDY, REBIF, RITUXAN, RUXIENCE, SOLIRIS, TRUXIMA, UPLIZNA, VUMERITY, and ZEPOSIA.

Yes (Deny)

(Go to #13)

No

(Go to #13)

13. Does the member have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days?

Yes (Deny)

(Go to #14)

No

(Go to #14)

14. Is the requested dose less than or equal to (\leq) 120 mg every two (2) weeks for three (3) doses, then 120 mg every four (4) weeks? [Manual]

Yes (Approve - 365 days)
(Go to #15)

No (Deny)
(Go to #15)

Additional Information

15. 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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