TEXAS MEDICAID
Clinical Edit Prior Authorization
teriflunomide (AUBAGIO)

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: CLINICAL PRIOR AUTHORIZATION CRITERIA

☐ Indicate Primary Diagnosis: _____ ICD 10 Code: _____

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

   ☐ Yes (Go to #2) ☐ No (Deny)

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

   ☐ Yes (Go to #3) ☐ No (Deny)

3. Is the client currently pregnant?

   ☐ Yes (Deny) ☐ No (Go to #4)

4. Does the client have a diagnosis of severe hepatic impairment in the last 365 days?

   ☐ Yes (Deny) ☐ No (Go to #5)

5. Does the client have a claim for leflunomide (ARAVA) in the last 90 days?

   ☐ Yes (Deny) ☐ No (Go to #6)

6. Does the client have a claim for rosuvastatin (CRESTOR, EZALLOR SPRINKLE) in the last 90 days

   ☐ Yes (Go to #7) ☐ No (Go to #8)

7. Is the dose of rosuvastatin less than or equal to (≤) 10mg/day?

☐ Yes (Go to #8) ☐ No (Deny)

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

☐ Yes (Approve – 365 days) ☐ No (Deny)

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.