



TEXAS MEDICAID Clinical Edit Prior Authorization Phosphate Binders

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: MEDICATION INFORMATION

| | |
|------------------------------|----------------------|
| Medication Requested (Name): | Quantity Requested: |
| Dose Requested: | Dosing Instructions: |

Patient's Primary Diagnosis: _____ ICD 10 Code: _____

Indicate the drug's formulary status: *(Formulary available at www.txvendordrug.com)

Non-Preferred Drug (NPD or NAP Status, Go to Step 3 - PDL PA Criteria Applies)

OR Preferred Drug (Go to Step 4)

OR No Status, Drug is not in a Market Basket (Go to Step 4)

OR N/A as this request is for a CHIP / PERINATE client (Go to Step 4)

STEP 3: PDL PRIOR AUTHORIZATION CRITERIA FOR NON-PREFERRED PRODUCT

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the last 180 days?

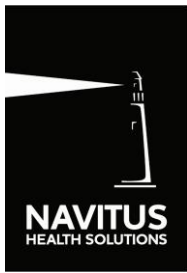
Yes (Go to Step 4, Question 1) No (Go to #2)

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

Yes (Go to Step 4, Question 1) No (Go to #3)

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

Yes (Go to Step 4, Question 1) No (Deny)



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STEP 4: CLINICAL PRIOR AUTHORIZATION CRITERIA

1. Does the client have a diagnosis of end stage renal disease (ESRD) in the last 730 days?

- Yes (Go to #2)
 No (And the request is for Auryxia, go to #3)
 No (And the request is for an agent other than Auryxia, deny)

2. Does the client have a diagnosis of hyperphosphatemia in the last 180 days?

- Yes (And the request is for Renvela or generic Renvela, go to #7)
 Yes (And the request is for an agent other than Renvela or generic Renvela, go to #8)
 No (And the request is for Auryxia, go to #3)
 No (And the request is for an agent other than Auryxia, deny)

3. Does the client have a diagnosis of iron deficiency anemia in the last 365 days?

- Yes (Go to #4) No (Go to #8)

4. Does the client have a diagnosis of chronic kidney disease (CKD) in the last 730 days?

- Yes (Go to #5) No (Deny)

5. Does the client have a history of dialysis in the last 180 days?

- Yes (Deny) No (Go to #6)

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

- Yes (Approve – 365 days) No (Deny)

7. Is the client greater than or equal to (\geq) 6 years and less than ($<$) 18 years of age?

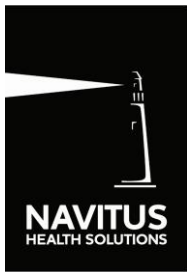
- Yes (Approve – 365 days) No (Go to #8)

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

- Yes (Go to #9) No (Deny)

9. Does the client have a diagnosis of hypercalcemia (corrected calcium lab value greater than ($>$) 10.2) or consecutive parathyroid hormone (PTH) lab values less than ($<$) 150 [manual step] in the last 180 days?

- Yes (And the request is for a non-calcium acetate containing product, approve – 365 days)
 Yes (And the request is for a calcium acetate containing product, deny)
 No (Go to #10)



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10. Does the client have a history of dialysis with severe vascular and/or soft tissue calcification in the last 180 days?

- Yes (And the request is for a non-calcium acetate containing product, approve – 365 days)
- Yes (And the request is for a calcium acetate containing product, deny)
- No (Approve – 365 days)

STEP 5: 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.