



TEXAS MEDICAID Clinical Edit Prior Authorization siponimod (MAYZENT)

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 (\geq) 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 medication being prescribed concurrently with other disease modifying therapies for MS?

Examples of disease modifying therapies include AUBAGIO, AVONEX PEN, BAFIERTAM DR, BETASERON, glatiramer (COPAXONE), dimethyl fumarate (TECFIDERA), EXTAVIA, GILENYA, GLATOPA, KESIMPTA, MAYZENT, mitoxantrone, PLEGRIDY, REBIF, REBIF REBIDOSE, VUMERITY, and ZEPOSIA

Yes (Deny)

No (Go to #4)

4. Does the client have a CYP2C9*3/*3 genotype? [Manual Step]

Yes (Deny)

No (Go to #5)



5. Does the client have a diagnosis of one of the following in the last 180 days?

- myocardial infarction (MI)
- unstable angina
- stroke
- decompensated heart failure requiring hospitalization
- transient ischemic attack (TIA)
- Class III/IV heart failure

Yes (Deny)

No (Go to #6)

6. Does the client have a history of Mobitz type II second-degree, third-degree atrioventricular (AV) block or sick sinus syndrome (unless the client has a functioning pacemaker) in the last 180 days?

Yes (Deny)

No (Go to #7)

7. Is the requested dose less than or equal to (\leq) 2mg/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.