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

TEXAS MEDICAID

Drug Prior Authorization
Monoclonal Antibodies: dupilumab (DUPIXENT)

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 #16)
- ◯ No Status, Drug is not in a Market Basket
  (Go to #16)
- ◯ N/A as this request is for a CHIP/PERINATE member
  (Go to #16)

Preferred Drug List (PDL) Criteria (required for non-preferred products)

7. Does the member have a diagnosis of atopic dermatitis (AD) in the last 365 days?

- ◯ Yes
  (Go to #8)
- ◯ No
  (Go to #9)

8. Has the member failed a 30-day treatment trial with at least one (1) preferred agent from the atopic dermatitis (AD), immunomodulators class in the last 180 days?

- ◯ Yes
  (Go to #16)
- ◯ No
  (Go to #9)

9. Does the member have a diagnosis of asthma in the last 365 days?

- ◯ Yes
  (Go to #10)
- ◯ No
  (Go to #11)

10. Has the member failed a 30-day treatment trial with at least one (1) preferred agent from the asthma immunomodulators class in the last 60 days?

- ◯ Yes (Go to #16)
- ◯ No (Go to #11)

11. Does the member have a diagnosis of rhinosinusitis with nasal polyposis in the last 365 days?

- ◯ Yes (Go to #12)
- ◯ No (Go to #13)

12. Has the member had a 30-day treatment trial with at least one (1) preferred agent from the intranasal rhinitis class in the last 60 days?

- ◯ Yes (Go to #16)
- ◯ No (Go to #13)

13. Does the member have a diagnosis of eosinophilic esophagitis (EoE) in the last 365 days?

- ◯ Yes (Go to #16)
- ◯ No (Go to #14)

14. Is there a documented allergy or contraindication to preferred agents in the appropriate class based on the member's diagnosis?

- ◯ Yes (Go to #16)
- ◯ No (Go to #15)

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

- ◯ Yes
  (Go to #16)
- ◯ No (Deny)
  (Go to #16)

Clinical Criteria (required)

16. Which of the following is the request for?

- ◯ Initial Therapy
  (Go to #17)
- ◯ Continuation of Therapy
  (Go to #30)

Initial Therapy

17. Is the member greater than or equal to (≥) six (6) months of age?

- ◯ Yes
  (Go to #18)
- ◯ No (Deny)
  (Go to #18)

18. Does the member have a diagnosis of moderate to severe atopic dermatitis (AD) in the last 365 days that involves greater than or equal to (≥) 10% of the member's body surface area (BSA)? [Manual Step]

- ◯ Yes
  (Go to #19)
- ◯ No
  (Go to #20)

19. Does the member have a claim for a topical corticosteroid and crisaborole (EUCRISA), pimecrolimus (ELIDEL), or tacrolimus (PROTOPIC) (topical) in the last 365 days?

Examples of topical corticosteroids include: amcinonide, betamethasone dipropionate (DIPROLENE, SERNIVO), betamethasone valerate, clobetasol (CLOBEX, OLUX, TEMOVATE), desoximetasone (TOPICORT), diflorasone (APEXICON), fluocinonide (VANOS), halobetasol (ULTRAVATE), HALOG, and triamcinolone (TRIANEX).

- ◯ Yes (Approve - 365 days)
  (Go to #32)
- ◯ No
  (Go to #20)

20. Is the member greater than or equal to (≥) six (6) years of age?

- ◯ Yes
  (Go to #21)
- ◯ No (Deny)
  (Go to #21)

21. Does the member have a diagnosis of moderate-to-severe asthma in the last 365 days?

- ◯ Yes
  (Go to #22)
- ◯ No
  (Go to #23)

22. Does the member have at least 30 days supply of an oral or inhaled corticosteroid in the last 60 days?

Examples of BOTH oral AND inhaled corticosteroids include: ADVAIR, ADVAIR HFA, AEROSPAN, ALVESCO, ARMONAIR, ARNUITY ELLIPTA, ASMANEX TWISTHALER, BREO ELLIPTA, budesonide (PLUMICORT), dexamethasone (DEXPAK, ZODEX), DULERA, FLOVENT, hydrocortisone (CORTEF), methylprednisolone (MEDROL), prednisolone (MILLIPRED, ORAPRED, VERIPRED), prednisone, QVAR, SYMBICORT, and TRELEGY ELLIPTA.

- ◯ Yes (Approved - 365 days)
  (Go to #32)
- ◯ No
  (Go to #23)

23. Is the member greater than or equal to (≥) 12 years of age?

- ◯ Yes
  (Go to #24)
- ◯ No
  (Go to #24)

24. Does the member have a diagnosis of eosinophilic esophagitis (EoE) in the last 365 days?

- ◯ Yes
  (Go to #25)
- ◯ No
  (Go to #26)

25. Does the member weigh greater than or equal to (≥) 40 kg? [Manual]

- ◯ Yes (Approve - 365 days)
  (Go to #32)
- ◯ No
  (Go to #26)

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

- ◯ Yes
  (Go to #27)
- ◯ No (Deny)
  (Go to #27)

27. Does the member have a diagnosis of chronic rhinosinusitis with nasal polyposis in the last 365 days?

- ◯ Yes
  (Go to #28)
- ◯ No
  (Go to #29)

28. Does the member have at least 60 days supply of intranasal corticosteroid in the last 90 days?

Examples of intranasal corticosteroids include: BECONASE AQ, budesonide, DYMISTA, flunisolide, fluticasone (XHANCE), mometasone furoate (NASONEX), QNASAL, and triamcinolone.

- ◯ Yes (Approve - 365 days)
  (Go to #32)
- ◯ No
  (Go to #29)

29. Does the member have a diagnosis of prurigo nodularis in the last 365 days?

- ◯ Yes (Approve - 365 days)
  (Go to #32)
- ◯ No (Deny)
  (Go to #32)

Continuation of Established Therapy

30. Does the member have a diagnosis of atopic dermatitis (AD), asthma, chronic rhinosinusitis with nasal polyposis, eosinophilic esophagitis (EoE), or prurigo nodulairis the last 365 days?

- ◯ Yes
  (Go to #31)
- ◯ No (Deny)
  (Go to #31)

31. Does the member continue to show improvement? [Manual step]

- ◯ Yes (Approve - 365 days)
  (Go to #32)
- ◯ No (Deny)
  (Go to #32)

Additional Information

32. 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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