TEXAS MEDICAID
Clinical Edit Prior Authorization
dupilumab (DUPIXENT) - Initial Requests

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: _____

Please indicate ONE (1) of the following:

☐ STAR / STAR KIDS client **(Go to Step 3 - PDL PA Criteria Applies)**

OR ☐ CHIP / PERINATE client **(Go to Step 4)**

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

1. Does the client have a diagnosis of atopic dermatitis in the last 365 days?

   ☐ Yes (Go to #2) ☐ No (Go to #3)

2. Has the client failed a 30-day treatment trial with at least 1 preferred agent from the atopic dermatitis, immunomodulators class in the last 180 days?

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

3. Does the client have a diagnosis of asthma in the last 365 days?

   ☐ Yes (Go to #4) ☐ No (Go to #5)

4. Has the client failed a 30-day treatment trial with at least 1 preferred agent from the asthma immunomodulators class in the last 60 days?

☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #5)

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

☐ Yes (Go #6) ☐ No (Go to #7)

6. Has the client had a 30-day treatment trial with at least 1 preferred agent from the intranasal rhinitis class in the last 60 days?

☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #7)

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

☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #8)

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

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

STEP 4: CLINICAL PRIOR AUTHORIZATION CRITERIA

1. Is the client greater than or equal to (≥) 6 years of age?

☐ Yes (Go to #2) ☐ No (Deny)

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

☐ Yes (Go to #3) ☐ No (Go to #4)

3. Does the client have a claim for a topical corticosteroid and crisaborole (EUCRISA) in the last 365 days?

Examples of topical corticosteroids include amcinonide, betamethasone (BETA-VAL, DIPROLENE, SERNIVO), clobetasol (CLOBEX, CORMAX, OLUX, TEMOVATE), desoximetasone (TOPICORT), diflorasone (APEXICON), fluocinonide (VANOS), halobetasol (ULTRAVATE), HALOG, and triamcinolone (TRIANEX)

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

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

☐ Yes (Go to #5) ☐ No (Deny)

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

☐ Yes (Go to #6) ☐ No (Go to #7)

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

Examples of oral corticosteroids include budesonide enteric coated (EC), dexamethasone (DEXPAK, ZODEX), hydrocortisone (CORTEF, HYDROCORTONE), methylprednisolone (MEDROL), prednisolone (MILLIPRED, ORAPRED, VERIPRED), and prednisone.

Examples of inhaled corticosteroids include ADVAIR, AEROSPAN, ALVESCO, ARMONAIR RESPICLICK, ARNUITY ELLIPTA, ASMANEX TWISTHALER, BREO ELLIPTA, budesonide (PULMICORT), DULERA, FLOVENT, QVAR, QVAR REDIHALER, SYMBICORT, and TRELEGY ELLIPTA.

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

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

☐ Yes (Go to #8) ☐ No (Deny)

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

☐ Yes (Go to #9) ☐ No (Deny)

9. Does the client have at least 60 days supply of an intranasal corticosteroid in the last 90 days?

Examples include BECONASE AQ, budesonide, flunisolide, fluticasone propionate (DYMISTA, XHANCE), mometasone furoate (NASONEX), QNASL, and triamcinolone nasal sprays.

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

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.