TEXAS MEDICAID
Clinical Edit Prior Authorization
dupilumab (DUPIXENT) - Renewal 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. Does the client have a diagnosis of atopic dermatitis, asthma or chronic rhinosinusitis with nasal polyposis in the last 365 days?

☐ Yes (Go to #2) ☐ No (Deny)

2. Does the client continue to show improvement? [Manual Step]

☐ 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.