Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Dupixent (Dupilumab) (Medicaid)

This fax machine is located in a secure location as required by HIPAA Regulations. Complete / Review information, sign, and date. Fax signed forms to Molina Pharmacy Prior Authorization Department at **1-888-487-9251**. Please contact Molina Pharmacy Prior Authorization Department at **1-855-322-4080** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Dupixent (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)		
DUPIXENT 300 MG/2 ML PEN	DUPIXENT 300 MG/2 ML SAFE SYRG	DUPIXENT 200 MG/1.14 ML SYRING

Patient Information	
Patient Name:	
Patient ID:	
Patient DOB:	

Prescribing Physician	
Physician Name:	
Physician Phone:	
Physician Fax:	
Physician Address:	
City, State, Zip:	

Diagnosis:	ICD Code:
Directions for administration:	

*****Please include all relevant clinical notes, lab work, medication history and any other applicable documentation.**

Please circle the appropriate answer for each question.

1. Is the requested drug required per court order? (court order required) Y N
   If the answer to this question is yes, approved for 365 days.
   If the answer to this question is no, go to question 2.

2. Is this request for continuation of therapy? Y N
   If the answer to this question is yes, go to question 18.
   If the answer to this question is no, go to question 3.

3. Is the patient greater than or equal to 6 years of age? Y N
   If the answer to this question is yes, go to question 4.
   If the answer to this question is no, denied.

4. Does the patient have a diagnosis of moderate to severe atopic dermatitis in the last 365 days that involves greater than or equal to 10% of the patients body surface area? Y N
   If the answer to this question is yes, go to question 5.
   If the answer to this question is no, go to question 8.

5. Does the patient have a claim for a topical corticosteroid and crisaborole listed in Table 3a/3b in the last 365 days? Y N
If the answer to this question is yes, go to question 6.
If the answer to this question is no, denied.

6. Is this request for a non-preferred drug? Y N
If the answer to this question is yes, go to question 7.
If the answer to this question is no, approved for 365 days.

7. Has the patient failed a 30 day treatment trial with at least 1 preferred agent from the atopic dermatitis, immunomodulators class in the last 180 days? Y N
If the answer to this question is yes, approved for 365 days.
If the answer to this question is no, go to question 31.

8. Is the patient greater than or equal to 12 years of age? Y N
If the answer to this question is yes, go to question 9.
If the answer to this question is no, denied.

9. Does the patient have a diagnosis of moderate-to-severe asthma in the last 365 days ? Y N
If the answer to this question is yes, go to question 10.
If the answer to this question is no, go to question 13.

10. Does the patient have at least 30 days supply of an oral or inhaled corticosteroid in the last 60 days? Y N
If the answer to this question is yes, go to question 11.
If the answer to this question is no, denied.

11. Is this request for a non-preferred drug? Y N
If the answer to this question is yes, go to question 12.
If the answer to this question is no, approved for 365 days.

12. Has the patient failed a 30 day treatment trial with at least 1 preferred agent from the asthma immunomodulators class in the last 60 days? Y N
If the answer to this question is yes, approved for 365 days.
If the answer to this question is no, go to question 31.

13. Is the patient greater than or equal 18 years of age? Y N
If the answer to this question is yes, go to question 14.
If the answer to this question is no, denied.

14. Does the patient have a diagnosis of chronic rhinosinusitis with nasal polyposis in the last 365 days? Y N
If the answer to this question is yes, go to question 15.
If the answer to this question is no, denied.

15. Does the patient have at least 60 days supply of an intranasal corticosteroid in the last 90 days? Y N
If the answer to this question is yes, go to question 16.
If the answer to this question is no, denied.

16. Is this request for a non-preferred drug? Y N
If the answer to this question is yes, go to question 17.
If the answer to this question is no, approved for 365 days.

17. Has the patient failed a 30 day treatment trial with at least 1 preferred agent from the intranasal rhinitis class in the last 60 days? Y N
If the answer to this question is yes, approved for 365 days.
If the answer to this question is no, go to question 31.

18. Does the patient have a diagnosis of atopic dermatitis in the last 365 days? Y N
If the answer to this question is yes, go to question 19.
If the answer to this question is no, go to question 22.

19. Does the patient continue to show improvement? Y N
If the answer to this question is yes, go to question 20.
If the answer to this question is no, denied.

20. Is this request for a non-preferred drug? Y N
If the answer to this question is yes, go to question 21.
If the answer to this question is no, approved for 365 days.

21. Has the patient failed a 30-day treatment trial with at least 1 preferred agent from the atopic dermatitis, immunomodulators class in the last 180 days? Y N
If the answer to this question is yes, approved for 365 days.
If the answer to this question is no, go to question 31.

22. Does the patient have a diagnosis of asthma in the last 365 days? Y N
If the answer to this question is yes, go to question 23.
If the answer to this question is no, go to question 27.

23. Does the patient continue to show improvement? Y N
If the answer to this question is yes, go to question 24.
If the answer to this question is no, denied.

24. Is this request for a non-preferred drug? Y N
If the answer to this question is yes, go to question 25.
If the answer to this question is no, approved for 365 days.

25. Has the patient failed a 30 day treatment trial with at least 1 preferred agent from the asthma immunomodulators class in the last 60 days? Y N
If the answer to this question is yes, approved for 365 days.
If the answer to this question is no, go to question 31.

27. Does the patient have a diagnosis of chronic rhinosinusitis with nasal polyposis in the last 365 days? Y N
If the answer to this question is yes, go to question 28.
If the answer to this question is no, denied.

28. Does the patient continue to show improvement? Y N
If the answer to this question is yes, go to question 29.
If the answer to this question is no, denied.

29. Is this request for a non-preferred drug? Y N
If the answer to this question is yes, go to question 30.
If the answer to this question is no, approved for 365 days.

30. Has the patient failed a 30 day treatment trial with at least 1 preferred agent from the intranasal rhinitis class in the last 60 days? Y N
If the answer to this question is yes, approved for 365 days.
If the answer to this question is no, go to question 31.

31. Is there a documented allergy or contraindication to preferred agents in this class? Y N
If the answer to this question is yes, approved for 365 days.
If the answer to this question is no, go to question 32.

32. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions? Y N
If the answer to this question is yes, approved for 365 days.
If the answer to this question is no, denied.

Table 3a: Claim for a Topical Corticosteroid

Amcinonide 0.1% cream	Diprolene AF 0.05% cream
Amcinonide 0.1% lotion	Fluocinonide 0.05% cream

Amcinonide 0.1% ointment	Fluocinonide 0.05% gel
Apexicon 0.05% ointment	Fluocinonide 0.05% ointment
Apexicon E 0.05% cream	Fluocinonide 0.05% solution
Betamethasone DP 0.05% cream	Fluocinonide-E 0.05% cream
Betamethasone DP 0.05% lotion	Fluocinonide-emol 0.05% cream
Betamethasone DP 0.05% ointment	Halobetasol prop 0.05% cream
Betamethasone DP AUG 0.05% cream	Halobetasol prop 0.05% ointment
Betamethasone DP AUG 0.05% gel	Halog/ 0.1% cream
Betamethasone DP AUG 0.05% lotion	Halog 0.1% ointment
Betamethasone DP AUG 0.05% ointment	Olux 0.05% foam
Betamethasone VA 0.1% cream	Olux-E 0.05% foam
Betamethasone VA 0.1% lotion	Sernivo 0.05% spray
Betamethasone Valer 0.1% ointment	Temovate 0.05% cream
Beta-val 0.1% lotion	Temovate 0.05% ointment
Clobetasol 0.05% cream	Topicort 0.05% gel
Clobetasol 0.05% gel	Topicort 0.25% cream
Clobetasol 0.05% ointment	Topicort 0.25% ointment
Clobetasol 0.05% solution	Topicort LP 0.05% cream
Clobetasol emollient 0.05% cream	Triamcinolone 0.025% cream
Clobetasol prop 0.05% foam	Triamcinolone 0.025% lotion
Clobex 0.05% spray	Triamcinolone 0.025% ointment
Clobex 0.05% topical lotion	Triamcinolone 0.1% cream
Cormax 0.05% solution	Triamcinolone 0.1% lotion
Desoximetasone 0.05% cream	Triamcinolone 0.1% ointment
Desoximetasone 0.05% gel	Triamcinolone 0.5% cream
Desoximetasone 0.25% cream	Triamcinolone 0.5% ointment
Desoximetasone 0.25% ointment	Trianex 0.05% ointment
Diflorasone 0.05% cream	Ultravate 0.05% cream
Diflorasone 0.05% ointment	Vanos 0.1% cream
Diprolene 0.05% lotion	
Diprolene 0.05% ointment	

Table 3b: Claim for Crisaborole

Eucrisa 2% Ointment

Comments:

I affirm that the information given on this form is true and accurate as of this date.

_____ _____

Prescriber (or Authorized) Signature Date