Amerigroup

Medicaid

https://provider.amerigroup.com/TX

Dupixent (dupilumab)
Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-474-3341.

1. Patient information	**2. Physician information**
Patient name: _____	Prescribing physician:_____
Patient ID #:_____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx:_____	Physician fax #:_____
Patient phone #: _____	Physician specialty: _____
Patient email address:_____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
Dupixent (dupilumab)			Specify:
7. Diagnosis:			

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

For initial therapy:

□ Yes □ No 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 percent of the patient's body surface area?

□ Yes □ No Does the client have a diagnosis of moderate to severe asthma in the last 365 days?

□ Yes □ No Does the client have a diagnosis of chronic rhinosinusitis with nasal polyposis in the last 365 days?

□ Yes □ No Does the client have a diagnosis of eosinophilic esophagitis in the last 365 days?

For renewal therapy:

□ Yes □ No Does the client have a diagnosis of atopic dermatitis, asthma, or chronic rhinosinusitis with nasal polyposis in the last 365 days?

□ Yes □ No Does the patient continue to show improvement?

□ Yes □ No Has the client had inadequate response or intolerance to TNF-blockers?

□ Yes □ No Patient has failed a 30-day treatment trial with at least one preferred agent(s) within the past 180 days.

□ Yes □ No Patient has a documented allergy or contraindication to preferred agents in this class.

□ Yes □ No Patient is being treated for stage-four advanced, metastatic cancer and associated conditions.

□ Yes □ No Does the client have a diagnosis of atopic dermatitis, asthma, chronic rhinosinusitis with nasal polyposis or eosinophilic esophagitis in the last 365 days?

For the *Texas Medicaid Preferred Drug List*, please refer to the Texas Medicaid Vendor Drug Program website at **https://www.txvendordrug.com/formulary/formulary-search**

Amerigroup members in the Medicaid Rural Service Area and the STAR Kids program are served by Amerigroup Insurance Company; all other Amerigroup members in Texas are served by Amerigroup Texas, Inc.

9. Physician signature

_____	_____
Prescriber or authorized signature	Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.