HIGHMARK. WEST VIRGINIA

PRESCRIPTION DRUG
MEDICATION REQUEST FORM
FAX TO 1-866-240-8123

DUPIXENT PRIOR AUTHORIZATION FORM

PATIENT INFORMATION

Subscriber ID Number		Group Number	
Patient Name	Patient Telephone Number		Date of Birth
Patient Address	City	State	Zip Code

PRESCRIBER INFORMATION

Physician Name	Phone		Fax
Physician Address	City	State	Zip Code
Suite / Building	Physician Signature		Date

MEDICATION INFORMATION

Requested Strength:

☐ 100mg/0.67ml Syringe ☐ 200mg/1.14ml Syringe ☐ 300mg/2ml Syringe

☐ 200mg/1.14ml Pen ☐ 300mg/2ml Pen

Quantity:

Does the patient require induction dosing of 4 pens/syringes for the first 4 weeks of therapy?

☐ Yes ☐ No

Number of **pens/syringes** per month for maintenance dosing:

Diagnosis:

CLINICAL CRITERIA

If Dupixent is being used to treat moderate-to-severe **atopic dermatitis**, please answer the following:

1. Dupixent is being prescribed by a:

   ☐ Dermatologist ☐ Allergist ☐ Immunologist ☐ Other: _____

2. Does the patient have atopic dermatitis with facial or anogenital involvement?

   ☐ Yes ☐ No

3. Has the patient met step therapy* requirements and experienced therapeutic failure, intolerance, or contraindication to any of the following?
   Please select **ALL** that apply:

   ☐ A topical corticosteroid (e.g. Betamethasone, Clobetasol, Triamcinolone, etc.)

   ☐ Topical Tacrolimus (Protopic)

   ☐ Topical Pimecrolimus (Elidel)

   *If requesting an exemption from step therapy, please provide clinical rationale: _____

   _____

4. Does the patient have severe atopic dermatitis with a large BSA (body surface area) which would make topical therapy impractical to apply?

   ☐ Yes ☐ No

5. Does the patient have severe atopic dermatitis with severely damaged skin?

   ☐ Yes ☐ No

6. Is this a request for reauthorization?

   ☐ Yes ☐ No

   a. If **YES**, has the patient experienced positive clinical response to therapy with Dupixent?

   ☐ Yes ☐ No

If Dupixent is being used to treat moderate-to-severe **asthma**, please answer the following:

1. Please provide **ALL** of the following:
   a. Patient's pretreatment FEV1: _____% predicted
2. Does the patient have FEV1 reversibility of at least 12% and 200 milliliters (ml) after albuterol (salbutamol) administration?
   ☐ Yes ☐ No
3. Does the patient have eosinophilic phenotype with blood eosinophil count greater than or equal to 150 cells/microliter?
   ☐ Yes ☐ No
4. Is the patient currently taking daily or alternate-day oral corticosteroids?
   ☐ Yes ☐ No
5. Is the patient using a medium- or high-dose inhaled corticosteroid?
   ☐ Yes ☐ No
6. Is the patient using a long-acting beta agonist?
   ☐ Yes ☐ No
7. Is this a request for reauthorization?
   ☐ Yes ☐ No
   a. If **YES**, please select **ALL** that apply:
      ☐ Patient has decreased rescue medication or oral corticosteroid use
      ☐ Patient had a decrease in frequency of severe asthma exacerbations
      ☐ Patient had an increase in pulmonary function from baseline (e.g. FEV1)
      ☐ Patient had a reduction in reported asthma-related symptoms (e.g. asthmatic symptoms upon awakening, coughing, fatigue, shortness of breath, sleep disturbance, or wheezing)

If Dupixent is being used to treat **chronic rhinosinusitis with nasal polyposis**, please answer the following:

1. Please provide:
   a. Patient's baseline bilateral nasal polyp score (**from 0 to 8**): _____
      The Nasal Polyp Score, the sum of right and left nostril scores, is used to characterize the patient's polyps. Each nostril is scored on a scale of 0 to 4, with the total score being the sum of left and right nostril scores.
      0 = no polyps
      4 = severe disease with large polyps causing complete obstruction of the inferior nasal cavity
   b. Patient's baseline nasal congestion score (**from 0 to 3**): _____
      The Nasal Congestion Score is a tool used to measure changes in nasal congestion and obstruction.
      0 = no symptoms
      3 = severe symptoms
2. Has the patient met step therapy* requirements and experienced therapeutic failure, intolerance, or contraindication to the following:
   Please select **ALL** that apply:
   ☐ An intranasal corticosteroid
   ☐ A 14-day course of oral corticosteroids
   *If requesting an exemption from step therapy, please provide clinical rationale: _____
   _____
3. Is this a request for reauthorization?
   ☐ Yes ☐ No
   a. If **YES**, please select **ALL** that apply:
      ☐ Patient has a decrease in the nasal polyp score
      ☐ Patient has a reduction in the nasal congestion/obstruction severity score

If Dupixent is being used to treat **eosinophilic esophagitis**, please answer the following:

1. Does the patient weigh at least 40 kg?
   ☐ Yes ☐ No

2. Does the patient have an esophageal eosinophil count greater than or equal to 15 eos/hpf (eosinophils/high power field) on esophageal biopsy?
   ☐ Yes ☐ No

3. Does the patient have clinical symptoms of esophageal dysfunction (e.g., dysphagia, food impaction, gastroesophageal reflux)?
   ☐ Yes ☐ No

4. Has the patient experienced two or more episodes of dysphagia per week?
   ☐ Yes ☐ No

5. Has the patient met step therapy* requirements and experienced therapeutic failure, contraindication, or intolerance to high-dose proton-pump inhibitor (PPI) therapy (e.g. omeprazole or pantoprazole 80 mg/day)?
   ☐ Yes ☐ No
   *If requesting an exemption from step therapy, please provide clinical rationale: _____

   _____

6. Is this a request for reauthorization?
   ☐ Yes ☐ No
   a. If **YES**, please select **ALL** that apply:
      ☐ Patient experienced histological remission (i.e. less than 15 eos/hpf) on esophageal biopsy
      ☐ Patient experienced reduced severity or frequency of dysphagia
      ☐ Patient experienced reduced severity or frequency of clinical symptoms of esophageal dysfunction (e.g. food impaction, gastroesophageal reflux)

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.

INSTRUCTIONS FOR COMPLETING THIS FORM

1. Submit a separate form for each medication.
2. Complete **ALL** information on the form.
   NOTE: *The prescribing physician (PCP or Specialist) should, in most cases, complete the form.*
3. Please provide the physician address as it is required for physician notification.
4. Fax the **completed** form and all clinical documentation to **1-866-240-8123**
   Or mail the form to: **Clinical Services,**
   120 Fifth Avenue, MC PAPHM-043B, Pittsburgh, PA 15222