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

DUPIXENT PRIOR AUTHORIZATION FORM

PATIENT INFORMATION

Subscriber's ID Number		Subscriber's Group Number
Patient's Name	Phone	Date of Birth

Address | City | State | Zip Code

PRESCRIBER INFORMATION

Physician's Name	NPI	Phone	Fax

Address | City | State | Zip Code

Suite / Building	Physician's 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. Has the patient experienced therapeutic failure, intolerance, or contraindication to any of the following? Please select **ALL** that apply:
   ☐ A generic topical corticosteroid (e.g. Betamethasone, Clobetasol, Triamcinolone, etc.)
   ☐ Generic topical Tacrolimus
   ☐ Generic topical Pimecrolimus
3. Does the patient have severe atopic dermatitis with a large BSA (body surface area) which would make topical therapy impractical to apply?
   ☐ Yes ☐ No
4. Does the patient have severe atopic dermatitis with severely damaged skin?
   ☐ Yes ☐ No
5. 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 experienced therapeutic failure, intolerance, or contraindication to the following:
   Please select **ALL** that apply:
   ☐ An intranasal corticosteroid
   ☐ A 14-day course of oral corticosteroids
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 experienced therapeutic failure, contraindication, or intolerance to high-dose proton-pump inhibitor (PPI) therapy (e.g. omeprazole or pantoprazole 80 mg/day)?
   ☐ Yes ☐ No
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)

If Dupixent is being used to treat **prurigo nodularis**, please answer the following:

1. Dupixent is being prescribed by a:
   ☐ Dermatologist ☐ Allergist ☐ Immunologist ☐ Other: _____
2. Has the patient experienced therapeutic failure, intolerance, or contraindication to one generic topical corticosteroid?
   ☐ Yes ☐ No
3. Does the patient have prurigo nodularis with a large BSA (body surface area) which would make topical therapy impractical to apply?
   ☐ Yes ☐ No
4. Does the patient have prurigo nodularis with severely damaged skin?
   ☐ Yes ☐ No
5. Is this a request for reauthorization?
   ☐ Yes ☐ No
   a. If **YES**, has the patient experienced a reduction in itch from baseline?
      ☐ Yes ☐ No

MEDICATION HISTORY

Please provide any other medications previously tried and failed for the patient's diagnosis:

_____

_____

_____

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