Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Dupixent (dupilumab)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication Requested: ☐ Dupixent 300mg/2ml syringe ☐ Dupixent 200mg/1.14ml syringe ICD10:

Directions for use: Quantity: Duration of therapy: J-Code:

Is this a new start or continuation of therapy? If your patient has already begun treatment with drug samples of Dupixent, please choose "new start of therapy". ☐ new start of therapy ☐ continued therapy

(if continued therapy) Has your patient had a good response to therapy with this drug (such as improvement, decreased exacerbations or oral steroid use)? Yes ☐ No ☐
(if no) Please provide clinical support for continued use of Dupixent.

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

*****Medication orders can be placed with Accredo via E-prescribe - Accredo (1640 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis:
☐ chronic rhinosinusitis with nasal polyposis (CRSwNP)
☐ moderate to severe atopic dermatitis
☐ moderate to severe asthma
☐ other (please specify):

Clinical Information

If atopic dermatitis:
Does your patient have a diagnosis of moderate to severe atopic dermatitis? Yes ☐ No ☐
Is there documentation that your patient has previously been treated for atopic dermatitis with any of the following: maintenance systemic corticosteroids (oral or injectable), cyclosporine (Sandimmune), azathioprine (Imuran), methotrexate, mycophenolate mofetil (Cellcept), and Actimmune? Yes ☐ No ☐

Is Dupixent being prescribed by, or in consultation with, an allergist, dermatologist, or immunologist? Yes ☐ No ☐

What topical corticosteroids (TSC) has your patient tried? (check all that apply)

Moderate potency TCS:

☐ clocortolone pivalate 0.1%
☐ fluocinolone 0.025% ointment
☐ flurandrenolide 0.05% ointment
☐ hydrocortisone valerate 0.2% ointment
☐ triamcinolone spray

High potency TCS:

☐ amcinonide 0.1% (cream, lotion, ointment)
☐ betamethasone dipropionate 0.05% (cream, ointment, spray)
☐ betamethasone valerate 0.1% (foam, ointment)
☐ clobetasol 0.025%
☐ desoximetasone 0.05% and 0.25% (cream, gel, ointment, spray)
☐ diflorasone 0.05%
☐ fluocinonide 0.05% (cream, gel, ointment, solution)
☐ fluticasone 0.005% (ointment)
☐ halcinonide 0.1% (cream, ointment)
☐ mometasone 0.1% (cream, lotion, ointment, solution)
☐ triamcinolone 0.5% and 0.1% (cream, ointment)

Very high potency TCS:

☐ augmented betamethasone dipropionate 0.05% (gel, lotion, ointment)
☐ clobetasol 0.05%
☐ Cordran 4mcg/cm2 tape
☐ fluocinonide 0.1% cream
☐ halobetasol 0.05% (cream, lotion, ointment)

Please provide the following details: drug name, strength, dosage form, date(s) taken and for how long, and what the documented results were of taking each drug, including any documented intolerances or adverse reactions your patient experienced.

Based on the answer above, did your patient have documented failure or inadequate response to a 4 week trial of moderate to high potency TCS? Yes ☐ No ☐

(if no) Based on the answer above, did your patient have documented failure or inadequate response to a 2 week trial of a very high potency TCS? Yes ☐ No ☐

(if no) Based on the answer above, did your patient have a documented intolerance to at least ONE moderate to very high potency TCS? Yes ☐ No ☐

(if no) Does your patient have a documented contraindication per FDA label or reason they are not a candidate for at least ONE moderate to very high potency TCS? Yes ☐ No ☐

(if no) Please list all contraindication(s) per FDA label that your patient has to using the listed topical corticosteroids, including any reason your patient is not a candidate to use these.

Has your patient tried Elidel, Protopic or tacrolimus ointment? Please provide the following details: drug name, strength, dosage form, date(s) taken and for how long, and what the documented results were of taking each drug, including any documented intolerances or adverse reactions your patient experienced.

Based on the answer above, did your patient have documented failure or inadequate response to a 6 week trial of ONE of the following: Elidel, Protopic or tacrolimus ointment? Yes ☐ No ☐

(if no) Based on the answer above, did your patient have a documented intolerance to at least ONE of the following: Elidel, Protopic or tacrolimus ointment? Yes ☐ No ☐

(if no) Does your patient have a documented contraindication per FDA label or reason they are not a candidate for at least ONE of the following: Elidel, Protopic or tacrolimus ointment? Yes ☐ No ☐

(if no) Please list all contraindication(s) per FDA label that your patient has to using the alternative(s), including any reason your patient is not a candidate to use the alternative(s).

If asthma:

While on Dupixent, will your patient continue to use an inhaled corticosteroid AND another controller therapy (for example, long-acting beta-agonist, leukotriene receptor)? Yes ☐ No ☐

(if asthma) Does your patient have reversibility of at least 12% and 200 mL in FEV1 after the administration of 200 to 400 mcg albuterol or levalbuterol? Yes ☐ No ☐

(if 12 to 17 years of age) Does your patient have a pre-bronchodilator FEV1 of 90% or LESS of predicted normal for adolescents? Yes ☐ No ☐

(if 18 years or older) Does your patient have a pre-bronchodilator FEV1 80% or LESS of predicted normal for adults? Yes ☐ No ☐

Besides the drug being requested, other antiasthmatic monoclonal antibody drugs (mAbs) include Cinqair, Fasenra, Nucala and Xolair. Which of the following best describes your patient's situation?

☐ The patient is NOT taking any other antiasthmatic mAbs at this time, nor will they in the future. The requested drug is the only mAb the patient is/will be using.

☐ The patient is currently on another antiasthmatic mAb, but this drug will be stopped and the requested drug will be started.

☐ The patient is currently on another antiasthmatic mAb, and the requested drug will be added. The patient may continue to take both drugs together.

☐ The patient is currently on BOTH the requested drug AND another antiasthmatic mAb.

☐ other/unknown

(if continuing use) Please provide name of drug and clinical rationale for the combined use of Dupixent and another monoclonal antibody to treat your patient's diagnosis.

Which of the following best describes your patient's asthma?

☐ eosinophilic asthma (EA)

☐ oral steroid dependent asthma (OSDA)

☐ neither of the above

(if EA) Prior to Dupixent, did/does your patient have a blood eosinophil level of at least 300 cells/mcl? Yes ☐ No ☐

(if no) Has your patient had a blood eosinophil level of at least 150 cells/mcl within the previous 6 weeks? Yes ☐ No ☐

(if EA) Does your patient have a history of 1 or more asthma exacerbations in the 12 months prior to adding Dupixent that required any of the following: treatment with systemic corticosteroids, an emergency department visit, or hospitalization for the treatment of asthma? Yes ☐ No ☐

(if EA) Prior to Dupixent, was your patient on either of the following for at least 3 months without adequate asthma control?

☐ a medium-dose inhaled corticosteroid (ICS) AND another controller therapy (for example, long-acting beta-agonist, leukotriene receptor)

☐ high-dose inhaled corticosteroid (ICS) AND another controller therapy (for example, long-acting beta-agonist, leukotriene receptor)

☐ neither of the above

(if OSDA) Prior to adding Dupixent, did your patient require prednisone daily, at least 5 mg (or an equivalent dose of another corticosteroid), for the previous 6 months? Yes ☐ No ☐

(if OSDA) Prior to Dupixent, was your patient on a high-dose inhaled corticosteroid (ICS) AND another controller therapy (for example, long-acting beta-agonist, leukotriene receptor) for at least 3 months without adequate asthma control? Yes ☐ No ☐

Is Dupixent being prescribed by, or in consultation with, an allergist, immunologist, or pulmonologist? Yes ☐ No ☐

If CRSwNP:

Is Dupixent being prescribed by, or in consultation with, an allergist, immunologist, or otolaryngologist (ear, nose, and throat [ENT])? Yes ☐ No ☐

Has your patient had chronic rhinosinusitis symptoms (for example, nasal obstruction, rhinorrhea, or reduction/loss of smell) for at least 12 weeks? Yes ☐ No ☐

Does your patient have evidence of nasal polyposis by direct examination, endoscopy, or sinus CT scan? Yes ☐ No ☐

Has your patient had an inadequate response to intranasal corticosteroid therapy at appropriate doses to treat nasal polyposis? Yes ☐ No ☐

Has your patient had prior surgery for nasal polyps? Yes ☐ No ☐

(if no) Has your patient received treatment with a systemic corticosteroid within the previous two years? Yes ☐ No ☐

(if no) Does your patient have a contraindication per FDA label to systemic corticosteroid therapy? Yes ☐ No ☐

While on Dupixent, will your patient continue to use intranasal corticosteroid therapy? Yes ☐ No ☐

(if no) Does your patient have an FDA contraindication and is unable to use intranasal corticosteroids? Yes ☐ No ☐

(if yes) Please list your patient's FDA contraindication for intranasal corticosteroid therapy. _____

Additional pertinent information *(Please include any alternatives (both non-drug and drug) tried, with drug/therapy name, date(s) taken and for how long, and what the documented results were of taking this drug or using this therapy, including any intolerances or adverse reactions your patient experienced.):*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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