

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

DUPIXENT PRIOR AUTHORIZATION FORM PATIENT INFORMATION						
Subscriber ID Number				Group Num	ber	
Patient Name			Patient Telephone Numb	per	Date of Birth	
Patient Address			City	State	Zip Code	
		PRESCRIBE	R INFORMATION			
Physician Name			Phone		Fax	
Physician Address			City	State	Zip Code	
Suite / Building Physician Signature					Date	
MEDICATION INFORMATION						
Requested Drug Strength:		□ 200mg/1.14mL	□ 300mg/2mL		Number of pens/syringes <u>per Month</u>	
Diagnosis:						
CLINICAL CRITERIA						
If Dupixent is being used to treat atopic dermatitis, please answer the following:						
1.	Dupixent is being prese	cribed by a:				
	Dermatologist	□ Allergist	🗆 Immunologis	t 🗆 (	Other:	
2.	<ol> <li>Does the patient have atopic dermatitis with facial or anogenital involvement?</li> <li>Yes</li> <li>No</li> </ol>					
3.	<ol> <li>Has the patient experienced therapeutic failure, intolerance, or contraindication to any of the following? Please select ALL that apply:</li> </ol>					
	<ul> <li>A topical corticoster</li> <li>Topical Tacrolimus</li> <li>Topical Pimecrolimu</li> </ul>	,	lobetasol, Triamcinol	one, etc.)		
4.	<ul> <li>Does the patient require induction dosing of 4 pens/syringes for the first 4 weeks of therapy?</li> <li>□ Yes</li> <li>□ No</li> </ul>					
5.	Is this a request for rea □ Yes □ No	authorization?				
	a. If <b>YES</b> , has the pat □ Yes □ No	tient experienced positive cl	inical response?			

If Dupi	xent is being used to treat <b>moderate-to-severe asthma</b> , please answer the following:			
1.	Please provide all of the following:			
	a. Patient's pretreatment forced expiratory volume in one second (FEV1):% predicted			
	b. Patient's FEV1 reversibility after albuterol (salbutamol) administration:%			
	c. Blood eosinophil count:cells/mcL			
2.	Is the patient currently taking daily or alternate-day oral corticosteroids?			
3.	Is the patient using a medium- or high-dose inhaled corticosteroid?			
4.	Is the patient using a long-acting beta agonist?			
5.	Does the patient require induction dosing of 4 pens/syringes for the first 4 weeks of therapy?			
6.	Is this a request for reauthorization?			
	a. If YES, please select ALL that apply:			
	Patient has demonstrated improvement or stability			
	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)			
	$\square$ 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:			
	<ul> <li>Patient's baseline bilateral nasal polyp score (from 0 to 8):</li> <li>The Nasal Polyp Score is used to characterize the patient's polyps (sum of the left and right nostril scores).</li> <li>0 = no polyps</li> </ul>			
	8 = severe disease with large polyps causing complete obstruction of the inferior nasal cavity			
	<ul> <li>b. Patient's baseline nasal congestion score (from 0 to 3):</li> <li>The Nasal Congestion Score is a tool used to measure changes in nasal congestion and obstruction.</li> <li>0 = no symptoms</li> <li>3 = severe symptoms</li> </ul>			
2.	Has the patient experienced therapeutic failure, intolerance, or contraindication to the following:			
	Please select <b>ALL</b> that apply:			
	<ul> <li>An intranasal corticosteroid</li> <li>A 14-day course of oral corticosteroids</li> </ul>			
3.	Is this a request for reauthorization?			
	a. If <b>YES</b> , please select <b>ALL</b> that apply:			
	□ Patient is responding to therapy			
	□ Patient has a decrease in their nasal polyp score			
	□ Patient has a reduction in their nasal congestion/obstruction severity score			
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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 <u>ALL</u> 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 <u>completed</u> form and all clinical documentation to 1-866-240-8123

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