PRIOR AUTHORIZATION REQUEST

Dupixent

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

1	Is the request an INITIAL or CONTINUATION of therapy? [] Initial (If checked, go to 6) [] Continuation (If checked, go to 2)		
2	Has the patient been receiving medication samples of Dupixent? [If yes, skip to question 6.]	Yes	No
3	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the	Yes	No

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	requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 6.]		
4	Has the patient been taking the requested medication for at least 4 months and has experienced a clinically significant benefit from the medication, as documented by the prescriber? ACTION REQUIRED: Submit supporting documentation. [Note: Asthma – Examples of a response to the requested medication are decreased asthma exacerbations; decreased asthma symptoms; decreased hospitalizations or emergency department visits due to asthma; decreased requirement for oral corticosteroid therapy. Atopic dermatitis – Examples of a response to the requested medication are marked improvements in erythema, induration/papulation/edema, excoriations, and lichenification; reduced pruritus; decreased requirement for other topical or systemic therapies; reduced body surface area affected with atopic dermatitis; or other responses observed. Nasal polyps – Examples of a response to the requested medication are reduced nasal polyp size, improved nasal congestion, reduced sinus opacification, decreased sinonasal symptoms, improved sense of smell. Eosinophilic esophagitis – Examples of response include: A) Reduced intraepithelial eosinophil count, B) Decreased dysphagia/pain upon swallowing, OR C) Reduced frequency/severity of food impaction Prurigo nodularis – Examples of response include: A) Reduced nodular lesion count, B) Decreased pruritus, OR C) Reduced nodular lesion size? COPD - Examples of a response to the requested medication are reduced COPD symptoms, reduced COPD exacerbations, reduced COP related hospitalization, reduced emergency department or urgent care visits or improved lung function paraments.] [If no, no further questions.]	Yes	No
5	Will the patient be concurrently receiving the requested medication in combination with any monoclonal antibody, anti-IL4, anti-IL5, or TSLP inhibitor such as Xolair, Cinqair, Fasenra, or Tezspire? [No further questions.]	Yes	No
6	What is the indication or diagnosis? [] Asthma (If checked, go to 7) [] Atopic dermatitis (If checked, go to 16) [] Nasal polyps (If checked, go to 47) [] Eosinophilic esophagitis (If checked, go to 58) [] Prurigo nodularis (If checked, go to 69) [] Chronic Obstructive Pulmonary Disease (If checked, go to 81)		

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	[] Other (If checked, no further questions)		
7	Is the patient greater than or equal to 6 years of age? [If no, no further questions.]	Yes	No
8	Is the requested medication being prescribed by or in consultation with an allergist, immunologist, or pulmonologist? [If no, no further questions.]	Yes	No
9	Will the patient be concurrently receiving the requested medication in combination with any monoclonal antibody, anti-IL4, anti-IL5, or TSLP inhibitor such as Xolair, Cinqair, Fasenra, or Tezspire? [If yes, no further questions.]	Yes	No
10	Has documentation been provided to confirm that the patient has a blood eosinophil level greater than or equal to 150 cells per microliter within the previous 6 weeks or within 6 weeks prior to treatment with any anti-interleukin therapy or Xolair? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of anti-interleukin therapies include Dupixent, Nucala (mepolizumab subcutaneous injection), Cinqair (reslizumab intravenous injection), and Fasenra (benralizumab subcutaneous injection).] [If yes, skip to question 12.]	Yes	No
11	Does the patient have oral (systemic) corticosteroid-dependent asthma per the prescriber (for example, the patient has received greater than or equal to 5 mg oral prednisone or equivalent per day for 6 months or greater)? [If no, no further questions.]	Yes	No
12	Has the patient had trial and failure for at least 3 consecutive months of combination therapy with BOTH of the following: A) An inhaled corticosteroid AND B) At least ONE additional asthma controller or asthma maintenance medication? [Note: Examples of additional asthma controller or asthma maintenance medications are inhaled long-acting beta2-agonists, inhaled long-acting muscarinic antagonists, leukotriene receptor antagonists, anti-interleukin-5 therapies (for example, Cinqair, Fasenra, Nucala), and theophylline. Use of a combination inhaler containing both an inhaled corticosteroid and a long-acting beta2-agonist would fulfil the requirement for both criteria A and B.] [If no, no further questions.]	Yes	No
13	Does the patient have asthma that is uncontrolled or was uncontrolled at baseline as defined by ONE of the following: A) The patient experienced two or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year, B) The patient experienced one or more asthma exacerbation(s) requiring hospitalization or an emergency department visit in the previous year, C) The patient has a forced expiratory volume in 1 second (FEV1) less than 80% predicted, D) The patient has an FEV1/forced vital capacity (FVC) less than 0.80, OR E) The patient has asthma that worsens upon tapering of oral corticosteroid	Yes	No

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	therapy? [Note: "Baseline" is defined as prior to receiving any Dupixent or other anti-interleukin- 5 therapies (that is, Cinqair, Fasenra, or Nucala).] [If no, no further questions.]		
14	Do the patient and prescriber agree to continue asthma therapy with an asthma controller maintenance medication in conjunction with the requested medication (inhaled ICS or ICS combination inhaler)? [If no, no further questions.]	Yes	No
15	Does the prescribed dosing exceed FDA approved indication? [No further questions.]	Yes	No
16	How old is the patient? [] Greater than or equal to 6 months of age (If checked, go to 17) [] Other (If checked, no further questions)		
17	Will the patient be concurrently receiving the requested medication in combination with any monoclonal antibody, anti-IL4, anti-IL5, or TSLP inhibitor such as Xolair, Cinqair, Fasenra, or Tezspire? [If yes, no further questions.]	Yes	No
18	Does the prescribed dosing exceed FDA approved indication? [If yes, no further questions.]	Yes	No
19	What is the patient's age? [] Greater than or equal to 6 months to less than or equal to 5 years of age (If checked, go to 20) [] Greater than or equal to 6 years to less than or equal to 11 years of age (If checked, go to 27) [] Greater than or equal to 12 years to less than or equal to 17 years of age (If checked, go to 37) [] Greater than or equal to 18 years of age (If checked, go to 37)		
20	Has documentation been provided to confirm that the patient has an IGA score of GREATER THAN OR EQUAL TO 3 and an EASI score of GREATHER THAN OR EQUAL to 16? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
21	Does the patient have atopic dermatitis involvement estimated to be greater than or equal to 10% of the body surface area (BSA) according to the prescriber? [If yes, skip to question 23.]	Yes	No
22	Does the patient have atopic dermatitis affecting the following areas: hands, face,	Yes	No

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	feet, eyes/eyelids, neck, scalp, skin folds, and/or genitalia? [If no, no further questions.]		
23	Has the patient tried at least TWO medium-, medium-high, high-, and/or super-high-potency prescription topical corticosteroids? [If no, no further questions.]	Yes	No
24	Has the patient tried tacrolimus ointment? [If no, no further questions.]	Yes	No
25	Were the topical corticosteroids and tacrolimus ointment applied daily for at least 28 consecutive days? [If no, no further questions.]	Yes	No
26	Was inadequate efficacy demonstrated with the topical therapies, according to the prescriber? [No further questions.]	Yes	No
27	Has documentation been provided to confirm that the patient has an IGA score of GREATER THAN OR EQUAL TO 4 and an EASI score of GREATHER THAN OR EQUAL to 21? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
28	Does the patient have atopic dermatitis involvement estimated to be greater than or equal to 10% of the body surface area (BSA) according to the prescriber? [If yes, skip to question 30.]	Yes	No
29	Does the patient have atopic dermatitis affecting the following areas: hands, face, feet, eyes/eyelids, neck, scalp, skin folds, and/or genitalia? [If no, no further questions.]	Yes	No
30	Has the patient tried at least TWO medium-, medium-high, high-, and/or super-high-potency prescription topical corticosteroids? [If no, no further questions.]	Yes	No
31	Has the patient tried tacrolimus ointment? [If no, no further questions.]	Yes	No
32	Were the topical corticosteroids and tacrolimus ointment applied daily for at least 28 consecutive days? [If no, no further questions.]	Yes	No
33	Was inadequate efficacy demonstrated with the topical therapies, according to the prescriber? [If no, no further questions.]	Yes	No
34	Has the patient tried Zoryve? [If no, no further questions]	Yes	No

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35	Was Zoryve applied daily for at least 56 consecutive days? [If no, no further questions.]	Yes	No
36	Was inadequate efficacy demonstrated with Zoryve, according to the prescriber? [No further questions.]	Yes	No
37	Has documentation been provided to confirm that the patient has an IGA score of GREATER THAN OR EQUAL TO 3 and an EASI score of GREATHER THAN OR EQUAL to 16? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
38	Does the patient have atopic dermatitis involvement estimated to be greater than or equal to 10% of the body surface area (BSA) according to the prescriber? [If yes, skip to question 40.]	Yes	No
39	Does the patient have atopic dermatitis affecting the following areas: hands, face, feet, eyes/eyelids, neck, scalp, skin folds, and/or genitalia? [If no, no further questions.]	Yes	No
40	Has the patient tried at least TWO medium-, medium-high, high-, and/or super-high-potency prescription topical corticosteroids unless treating the face or eyes/eyelid area? [If no, no further questions.]	Yes	No
41	Has the patient tried tacrolimus ointment? [If no, no further questions.]	Yes	No
42	Was Tacrolimus ointment applied daily for at least 28 consecutive days? [If no, no further questions.]	Yes	No
43	Was inadequate efficacy demonstrated with tacrolimus ointment, according to the prescriber? [If no, no further questions.]	Yes	No
44	Has the patient tried Zoryve? [If no, no further questions]	Yes	No
45	Was Zoryve applied daily for at least 56 consecutive days? [If no, no further questions.]	Yes	No
46	Was inadequate efficacy demonstrated with Zoryve, according to the prescriber? [No further questions.]	Yes	No
47	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
48	Is the requested medication prescribed by or in consultation with an allergist,	Yes	No

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	immunologist, or an otolaryngologist (ear, nose, and throat [ENT] physician specialist)? [If no, no further questions.]		
49	Will the patient concurrently be receiving the requested medication with any monoclonal antibody, anti-IL4, anti-IL5, or TSLP inhibitor such as Xolair, Cinqair, Fasenra, or Tezspire? [If yes, no further questions.]	Yes	No
50	Does the prescribed dosing exceed FDA approved indication? [If yes, no further questions.]	Yes	No
51	Does the patient have chronic rhinosinusitis with nasal polyposis as evidenced by direct examination, endoscopy, or sinus computed tomography (CT) scan? [If no, no further questions.]	Yes	No
52	Has the patient experienced TWO or more of the following symptoms for at least 6 months: A) Nasal congestion, B) Nasal obstruction, C) Nasal discharge, and/or D) Reduction/loss of smell? [If no, no further questions.]	Yes	No
53	Has the patient had trial and failure for at least 3 months of therapy with an intranasal corticosteroid unless contraindicated or intolerant to two products? [If no, no further questions.]	Yes	No
54	Will the patient continue to receive therapy with an intranasal corticosteroid concomitantly with the requested medication unless contraindicated or intolerant? [If no, no further questions.]	Yes	No
55	Has the patient received at least one course of treatment with a systemic corticosteroid for 5 days or more within the previous 2 years for the treatment of nasal polyps? [If yes, no further questions.]	Yes	No
56	Does the patient have a contraindication to systemic corticosteroid therapy? [If yes, no further questions.]	Yes	No
57	Has the patient had prior surgery for nasal polyps? [No further questions.]	Yes	No
58	Is the patient greater than or equal to 1 year of age? [If no, no further questions.]	Yes	No
59	Does the patient weight 15 kg or more? [If no, no further questions.]	Yes	No
60	Is the requested medication prescribed by or in consultation with an allergist or gastroenterologist?	Yes	No

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	[If no, no further questions.]		
61	Does the patient have a diagnosis of eosinophilic esophagitis confirmed by an endoscopic biopsy demonstrating GREATER THAN OR EQUAL TO 15 intraepithelial eosinophils per high-power field? [If no, no further questions.]	Yes	No
62	Does the patient have a secondary cause of eosinophilic esophagitis? [Note: Examples of secondary causes of eosinophilic esophagitis are hypereosinophilic syndrome, eosinophilic granulomatosis with polyangiitis, and food allergy.] [If yes, no further questions.]	Yes	No
63	Has the patient had trial and failure for at least 8 weeks of therapy with a proton pump inhibitor or topical (esophageal) corticosteroids (for example, budesonide, fluticasone)? [If no, no further questions.]	Yes	No
64	Has documentation been provided to confirm that the patient has symptoms of dysphagia due to esophageal dysfunction (food impaction, chest pain or GERD symptoms)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
65	Has the patient tried dietary modifications to treat/manage eosinophilic esophagitis? [Note: Examples of dietary modifications to treat eosinophilic esophagitis include an elemental diet or an elimination diet.] [If yes, skip to question 67.]	Yes	No
66	Has the provider determined that the patient is not an appropriate candidate for dietary modifications? [Note: Examples of dietary modifications to treat eosinophilic esophagitis include an elemental diet or an elimination diet.] [If no, no further questions.]	Yes	No
67	Does the prescribed dosing exceed FDA approved indication? [If yes, no further questions.]	Yes	No
68	Will the patient concurrently be receiving the requested medication with any monoclonal antibody, anti-IL4, anti-IL5, or TSLP inhibitor such as Xolair, Cinqair, Fasenra, or Tezspire? [No further questions.]	Yes	No
69	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
70	Is the requested medication prescribed by or in consultation with an allergist, immunologist, or dermatologist?	Yes	No

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	[If no, no further questions.]		
71	Does the patient have GREATER THAN OR EQUAL TO 20 identifiable nodular lesions in total on both arms, and/or both legs, and/or trunk? [If no, no further questions.]	Yes	No
72	Has the patient experienced pruritus for 6 weeks or longer? [If no, no further questions.]	Yes	No
73	Does the patient have a secondary cause of prurigo nodularis that has been identified (such as, medication induced, non- dermatologic condition such as neuropathy or psychiatric disease)? [If no, skip to question 75.]	Yes	No
74	Has the secondary cause been adequately managed according to the prescriber? [If no, no further questions.]	Yes	No
75	Has the patient tried at least TWO high- or super-high-potency prescription topical corticosteroid? [If no, no further questions.]	Yes	No
76	Was the topical corticosteroid applied daily for at least 14 consecutive days? [If no, no further questions.]	Yes	No
77	Was inadequate efficacy demonstrated with the topical corticosteroid therapy, according to the prescriber? [If no, no further questions.]	Yes	No
78	Has the patient tried and failed at least TWO traditional systemic agents for prurigo nodularis for at least 3 months? [Note: Examples include systemic immunosuppressants, topical calcineurin inhibitors, or psoralen plus ultraviolet A light (PUVA).] [If no, no further questions.]	Yes	No
79	Does the prescribed dosing exceed FDA approved indication? [If yes, no further questions.]	Yes	No
80	Will the patient concurrently be receiving the requested medication with any monoclonal antibody, anti-IL4, anti-IL5, or TSLP inhibitor such as Xolair, Cinqair, Fasenra, or Tezspire? [No further questions.]	Yes	No
81	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
82	Is the requested medication being prescribed by or in consultation with an allergist, immunologist, or pulmonologist? [If no, no further questions]	Yes	No

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83	Does the patient have a blood eosinophil greater than or equal to 300 cells/microliter within the last 6 weeks? [If yes, skip to question 85.]	Yes	No
84	Does the patient have a blood eosinophil ≥ 300 cells/μL prior to treatment with Dupixent or another monoclonal antibody therapy? [Note: Examples of monoclonal antibody treatment: Adbry (tralokinumab-ldrm subcutaneous injection), Cinqair (reslizumab intravenous infusion), Ebglyss (lebrikizumablbkz subcutaneous injection), Fasenra (benralizumab subcutaneous injection), Nemluvio (nemolizumab-ilto subcutaneous injection); Nucala (mepolizumab subcutaneous injection), Tezspire (tezepelumab subcutaneous injection), and Xolair (omalizumab subcutaneous injection]. [If no, no further questions.]	Yes	No
85	Has the patient received at least 3 CONSECUTIVE months of therapy with an inhaled long-acting beta$_2$-agonist (LABA) and inhaled long-acting muscarinic antagonist (LAMA) and Inhaled corticosteroid (ICS)? [If no, no further questions.]	Yes	No
86	Has the patient had signs or symptoms of chronic bronchitis (for example, chronic productive cough) for greater than or equal to 3 months in the previous 12 months? [If no, no further questions.]	Yes	No
87	Has the patient had at least 2 moderate exacerbations within the last year? [Note: moderate exacerbation defined as requiring treatment with a systemic glucocorticoid, an antibiotic agent, or both.] [If yes, skip to question 89.]	Yes	No
88	Has the patient had at least 1 severe exacerbation within the last year? [Note: Severe exacerbation defined as hospitalization or an emergency medical visit.] [If no, no further questions]	Yes	No
89	Have one or more of the exacerbations occurred while the patient was receiving combination therapy with an ICS, LAMA and LABA? [If no, no further questions]	Yes	No
90	Will the patient be concurrently receiving the requested medication in combination with any monoclonal antibody, anti-IL4, anti-IL5, or TSLP inhibitor such as Xolair, Cinqair, Fasenra, or Tezspire? [If yes, no further questions.]	Yes	No
91	Does the prescribed dosing exceed FDA approved indication?	Yes	No

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Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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