PRIOR AUTHORIZATION REQUEST
Dupixent (dupilumab)

PATIENT: Name_____
Address: _____
City, State, Zip_____
D.O.B. _____
Member ID:_____

Prescriber: Name_____
Address _____
City, State, Zip_____
Phone _____
Fax _____
NPI _____

Medication Requested:_____ Qty Requested: _____

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 answer the following questions

1. θ Yes θ No Will the requested medication be used in combination with another anti- Interleukin monoclonal antibody therapy?
   →If NO, please proceed to question 2

2. θ Yes θ No Will the requested medication be used in combination with Xolair?
   →If NO, please proceed to question 3

3. What is the indication or diagnosis?
   θ Asthma →please proceed to question 4
   θ Atopic dermatitis →please proceed to question 18
   θ Eosinophilic esophagitis
   θ Nasal polyps →please proceed to question 37
   θ All other indications or diagnoses

4. θ Yes θ No Is the medication being prescribed by or in consultation with an allergist, immunologist, or pulmonologist?
   →If YES, please proceed to question 5

5. θ Yes θ No 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 NO, please proceed to question 6

6. θ Yes θ No Is the patient currently receiving requested medication?
   →If YES, please proceed to question 7

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7. Has the patient already received at least 4 months of therapy with the requested medication? Note: A patient who has received less than 4 months of therapy or who is restarting therapy with the requested medication should be considered under Initial Therapy.
θ Yes →please proceed to question 8
θ No. Proceed to initial therapy. →please proceed to question 12

8. θ Yes θ No Does the patient have a documented clinical response to therapy as determined by the prescriber? Note: 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.
→If YES, please proceed to question 9

9. θ Yes θ No Does the patient have a previously approved PA on file with the current plan? Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.
→If YES, please proceed to question 10
→If NO, please proceed to question 11

10. θ Yes θ No Does the patient continue to receive therapy with one inhaled corticosteroid or one inhaled corticosteroid-containing combination inhaler?

11. θ Yes θ No Has the patient been receiving medication samples for the requested medication?
→If NO, please proceed to question 12

12. θ Yes θ No 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? Note:Examples of anti-interleukin therapies include Dupixent, Nucala (mepolizumab subcutaneous injection), Cinqair (reslizumab intravenous injection), and Fasenra (benralizumab subcutaneous injection). Note: Medical documentation specific to your response to this question must be attached to this case or your request could be denied.
→If YES, please proceed to question 14
→If NO, please proceed to question 13

13. θ Yes θ No Does the patient have oral (systemic) corticosteroid-dependent asthma per the prescriber (for example, the patient has received 5 mg oral prednisone or greater or equivalent per day for 6 months or greater)?
→If YES, please proceed to question 14

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14. θ Yes θ No Has the patient received at least 3 consecutive months of combination therapy with BOTH of the following (a and b): 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 YES, please proceed to question 15

15. θ Yes θ No Does the patient have asthma that is uncontrolled or was uncontrolled at baseline as defined by ONE of the following (a, b, c, d, or e): (a) the patient experienced two or more asthma exacerbations requiring treatment with systemic corticosteroids in theprevious 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 therapy. Note: "Baseline" is defined as prior to receiving any Dupixent or other anti-interleukin- 5 therapies (that is, Cinqair, Fasenra, or Nucala).
→If YES, please proceed to question 16

16. θ Yes θ No 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 YES, please proceed to question 17

17. θ Yes θ No Does the prescribed dosing exceed FDA approved indication?

18. θ Yes θ No Does the patient have a documented diagnosis of moderate to severe atopic dermatitis?
→If YES, please proceed to question 19

19. θ Yes θ No Is the requested medication being prescribed by or in consultation with an allergist, immunologist, or dermatologist?
→If YES, please proceed to question 20

20. θ Yes θ No Does the prescribed dosing exceed FDA approved indication?
→If NO, please proceed to question 21

21. θ Yes θ No Will the patient concurrently be receiving the requested medication in combination with

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any monoclonal antibody, anti-IL4, anti-IL5, or TSLP inhibitor such as Xolair, Adbry, Cinqair, Fasenra, or Tezspire?
→If NO, please proceed to question 22

22. θ Yes θ No Is the patient currently receiving requested medication?
→If YES, please proceed to question 23
→If NO, please proceed to question 27

23. Has the patient already received at least 4 months of therapy with the requested medication? Note: A patient who has received less than 4 months of therapy or who is restarting therapy with the requested medication should be considered under Initial Therapy.
θ Yes →please proceed to question 24
θ No. Proceed to initial therapy. →please proceed to question 27

24. θ Yes θ No Does the patient have a documented clinical response to therapy as determined by the prescriber? Note: 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.
→If YES, please proceed to question 25

25. θ Yes θ No Does the patient have a previously approved PA on file with the current plan? Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.
→If NO, please proceed to question 26

26. θ Yes θ No Has the patient been receiving medication samples for the requested medication?
→If NO, please proceed to question 27

27. 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?
θ Yes. (Greater than or Equal to 10% of the BSA) →please proceed to question 28
θ No. (Less than 10% of the BSA) →please proceed to question 32

28. θ Yes θ No Has the patient tried at least two medium-, medium-high, high-, and/or super-high-potency prescription topical corticosteroids?
→If YES, please proceed to question 29

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29 . θ Yes θ No Has the patient tried tacrolimus ointment?
→If YES, please proceed to question 30

30. θ Yes θ No Were the topical corticosteroids and tacrolimus ointment applied daily for at least 28 consecutive days?
→If YES, please proceed to question 31

31. θ Yes θ No Was inadequate efficacy demonstrated with the topical therapies, according to the prescriber?

32. θ Yes θ No Does the patient have atopic dermatitis affecting ONLY the following areas: face, eyes/eyelids, skin folds, and/or genitalia?
→If YES, please proceed to question 33

33. θ Yes θ No 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 YES, please proceed to question 34

34. θ Yes θ No Has the patient tried tacrolimus ointment?
→If YES, please proceed to question 35

35. θ Yes θ No Was Tacrolimus ointment applied daily for at least 28 consecutive days?
→If YES, please proceed to question 36

36. θ Yes θ No Was inadequate efficacy demonstrated with tacrolimus ointment, according to the prescriber?

37. θ Yes θ No Does the patient have chronic rhinosinusitis with nasal polyposis as evidenced by direct examination, endoscopy, or sinus computed tomography (CT) scan?
→If YES, please proceed to question 38

38. θ Yes θ No Is the requested medication prescribed by or in consultation with an allergist, immunologist, or an otolaryngologist (ear, nose, and throat [ENT] physician specialist)?
→If YES, please proceed to question 39

39. θ Yes θ No 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 NO, please proceed to question 40

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40 . θ Yes θ No Does the prescribed dosing exceed FDA approved indication?
→If NO, please proceed to question 41

41. θ Yes θ No Is the patient currently receiving requested medication?
→If YES, please proceed to question 42
→If NO, please proceed to question 47

42. Has the patient already received at least 4 months of therapy with the requested medication? Note: A patient who has received less than 4 months of therapy or who is restarting therapy with the requested medication should be considered under Initial Therapy.
θ Yes →please proceed to question 43
θ No. Proceed to initial therapy. →please proceed to question 47

43 . θ Yes θ No Does the patient have a documented clinical response to therapy as determined by the prescriber? Note: 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.
→If YES, please proceed to question 44

44. θ Yes θ No Does the patient have a previously approved PA on file with the current plan? Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.
→If YES, please proceed to question 45
→If NO, please proceed to question 46

45 . θ Yes θ No Does the patient continue to receive therapy with an intranasal corticosteroid concurrently with the requested medication unless contraindicated or intolerant?

46. θ Yes θ No Has the patient been receiving medication samples for the requested medication?
→If NO, please proceed to question 47

47. θ Yes θ No Has the patient experienced two or more of the following symptoms for at least 6 months: nasal congestion, nasal obstruction, nasal discharge, and/or reduction/loss of smell?
→If YES, please proceed to question 48

48. θ Yes θ No Has the patient received at least 3 months of therapy with an intranasal corticosteroid unless contraindicated or intolerant to two products?
→If YES, please proceed to question 49

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49. θ Yes θ No Will the patient continue to receive therapy with an intranasal corticosteroid concomitantly with the requested medication unless contraindicated or intolerant?
→If YES, please proceed to question 50

50. θ Yes θ No 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 NO, please proceed to question 51

51. θ Yes θ No Does the patient have a contraindication to systemic corticosteroid therapy?
→If NO, please proceed to question 52

52. θ Yes θ No Has the patient had prior surgery for nasal polyps?

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: 877-251-5896

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