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. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

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 the requested medication? [If yes, skip to question 6.]	Yes	No

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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 requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 6.]	Yes	No
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 include decreased asthma exacerbations, decreased asthma symptoms, decreased hospitalizations or emergency department visits due to asthma, or decreased requirement for oral corticosteroid therapy. Atopic dermatitis – Examples of a response include 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 include reduced nasal polyp size, improved nasal congestion, reduced sinus opacification, decreased sinonasal symptoms, or improved sense of smell. Eosinophilic esophagitis – Examples of response include reduced intraepithelial eosinophil count, decreased dysphagia/pain upon swallowing, or reduced frequency/severity of food impaction. Prurigo nodularis – Examples of response include reduced nodular lesion count, decreased pruritus, or reduced nodular lesion size. Chronic Obstructive Pulmonary Disease (COPD) – Examples of a response include are reduced COPD symptoms, reduced COPD exacerbations, reduced COPD related hospitalization, reduced emergency department or urgent care visits or improved lung function paraments. Chronic spontaneous urticaria – Examples of a response include decreased itch severity, decreased number of hives and/or decreased size of hives. Bullous pemphigod – Examples of a response include decreased blister formation and pruritus and promote healing of blisters and erosions.] [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

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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) [] Chronic Spontaneous Urticaria (If checked, go to 92) [] Bullous Pemphigod (If checked, go to 99) [] 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?	Yes	No

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	[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, or 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.]		
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 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.]	Yes	No
14	Do the patient and prescriber agree to continue asthma therapy with an asthma controller maintenance medication in conjunction with the requested medication (Inhaled corticosteroid (ICS) or ICS combination inhaler)? [If no, no further questions.]	Yes	No
15	Does the prescribed dosing exceed FDA approved indication? [Dosing: Children age 6 to less than 12 years: 15 to less than 30 kg: 300 mg every 4 weeks; greater than or equal to 30 kg: 200 mg every 2 weeks; Greater than or equal 12 years of age: 400 mg once, followed by 200 mg every other week OR 600 mg once, followed by 300 mg every other week.] [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		

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	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, feet, eyes/eyelids, neck, scalp, skin folds, and/or genitalia? [If no, no further questions.]	Yes	No
23	Has the patient tried at least TWO medium-, medium-high, high-, and/or super-high-potency prescription topical corticosteroids unless treating the face area? [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,	Yes	No

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	feet, eyes/eyelids, neck, scalp, skin folds, and/or genitalia? [If no, no further questions.]		
30	Has the patient tried at least TWO medium-, medium-high, high-, and/or super-high-potency prescription topical corticosteroids unless treating the face area? [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
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 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?	Yes	No

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	[If no, no further questions.]		
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, immunologist, or an otolaryngologist (ear, nose, and throat [ENT] physician specialist)? [If no, no further questions.]	Yes	No
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

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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 weigh 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? [If no, no further questions.]	Yes	No
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, or 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

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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? [Dosing: 300 mg once weekly.] [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? [If no, no further questions.]	Yes	No
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

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78	Has the patient tried and failed at least TWO traditional agents for prurigo nodularis for at least 3 months? [Note: Examples include systemic immunosuppressants or topical calcineurin inhibitors.] [If no, no further questions.]	Yes	No
79	Does the prescribed dosing exceed FDA approved indication? [Dosing: 600 mg once, followed by 300 mg once every other week.] [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
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 greater than or equal to 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 beta2-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.]	Yes	No

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	[If yes, skip to question 89.]		
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? [Dosing: 300 mg once every other week.] [No further questions.]	Yes	No
92	Is the patient greater than or equal to 12 years of age? [If no, no further questions.]	Yes	No
93	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
94	Has documentation been submitted that the patient has/had urticaria greater than 6 weeks (prior to treatment with requested medication), with symptoms present greater than 3 days per week? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
95	Has documentation been submitted the patient has been on daily non-sedating H1 antihistamine therapy with doses that have been titrated up to a maximum of four times the standard FDA-approved dose? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of non-sedating H1 antihistamine therapy are cetirizine, fexofenadine, or loratadine.] [If no, no further questions.]	Yes	No
96	Has the patient been evaluated for skin morbidities and other causes of urticaria? [If no, no further questions]	Yes	No
97	Is the requested medication being prescribed by or in consultation with an allergist, immunologist, or pulmonologist?	Yes	No

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	[If no, no further questions.]		
98	Does the prescribed dosing exceed FDA approved indication? [Dosing: 600 mg once, followed by 300 mg once every other week.] [No further questions.]	Yes	No
99	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
100	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
101	Has the patient ever been treated with an anti-IL4 or anti-IL13 monoclonal antibody? [If yes, no further questions.]	Yes	No
102	Has the patient been treated with any other biologic or intravenous immunoglobulin (IVIG) medications within the last 16 weeks? [If yes, no further questions]	Yes	No
103	Has the patient tried at least TWO medium-, medium-high, high-, and/or super-high-potency prescription topical corticosteroids unless treating the face area? [If no, no further questions.]	Yes	No
104	Has documentation been submitted to show the patient has tried oral doxycycline for at least 3 months? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
105	Is the requested medication being prescribed by or in consultation with an allergist, immunologist, or dermatologist? [If no, no further questions.]	Yes	No
106	Does the prescribed dosing exceed FDA approved indication? [Dosing: 600 mg once, followed by 300 mg once every other week.]	Yes	No

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

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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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