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

If you have any questions, call: 1-888-258-8250

Version 09.2026

PRIOR AUTHORIZATION REQUEST

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 3 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. Allergic Fungal Rhinosinusitis – Examples of a response include reduced nasal polyp size, improved nasal congestion, reduced sinus opacification, decreased	Yes	No

PRIOR AUTHORIZATION REQUEST

	sinonasal symptoms, improved sense of smell, reduced use of systemic corticosteroids.] [If no, no further questions.]		
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	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
7	What is the indication or diagnosis? [] Asthma (If checked, go to 8) [] Atopic dermatitis (If checked, go to 16) [] Nasal polyps (If checked, go to 31) [] Eosinophilic esophagitis (If checked, go to 41) [] Prurigo nodularis (If checked, go to 51) [] Chronic Obstructive Pulmonary Disease (If checked, go to 62) [] Chronic Spontaneous Urticaria (If checked, go to 71) [] Bullous Pemphigod (If checked, go to 77) [] Allergic Fungal Rhinosinusitis (If checked, go to 84) [] Other (If checked, no further questions)		
8	Is the patient greater than or equal to 6 years of age? [If no, no further questions.]	Yes	No
9	Is the requested medication being prescribed by or in consultation with an allergist, immunologist, or pulmonologist? [If no, 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	Yes	No

PRIOR AUTHORIZATION REQUEST

	injection), and Fasenra (benralizumab subcutaneous injection).] [If yes, skip to question 12.]		
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, 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.]	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 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 requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? Note: Dosing is: 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 to 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	What is the patient's age? [] Greater than or equal to 6 months to less than 2 years of age (If checked, go to		

PRIOR AUTHORIZATION REQUEST

	17) [] Greater than or equal to 2 years to less than 6 years of age (If checked, go to 23 [] Greater than or equal to 6 years to less than or equal to 12 years of age (If checked, go to 24) [] Greater than or equal to 12 years (If checked, go to 23)		
17	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
18	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 21.]	Yes	No
19	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
20	Has documentation been submitted to confirm that the patient has had treatment failure with TWO medium-, medium-high, high-, and/or super-high-potency prescription topical corticosteroids unless intolerant or the medication is contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
21	Has documentation been submitted to confirm that the patient has had a treatment failure with Eucrisa for AT LEAST 28 consecutive days unless intolerant or the medication is contraindicated? ACTION REQUIRED: Submit supporting documentation. [Note: Patient should only use the 60 gram tube.] [If no, no further questions.]	Yes	No
22	Has documentation been submitted to confirm that the patient has had a treatment failure with pimecrolimus OR tacrolimus for AT LEAST 28 consecutive days unless intolerant or the medication is contraindicated? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
23	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 yes, skip to question 25.] [If no, no further questions.]	Yes	No

PRIOR AUTHORIZATION REQUEST

24	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
25	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 28.]	Yes	No
26	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
27	Has documentation been submitted to confirm that the patient has had treatment failure with TWO medium-, medium-high, high-, and/or super-high-potency prescription topical corticosteroids unless intolerant or the medication contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
28	Has documentation been submitted to confirm that the patient has had a treatment failure with Eucrisa for AT LEAST 28 consecutive days unless intolerant or the medication is contraindicated? ACTION REQUIRED: Submit supporting documentation. [Note: Patient should only use the 60 gram tube.] [If no, no further questions.]	Yes	No
29	Has documentation been submitted to confirm that the patient has had a treatment failure with pimecrolimus OR tacrolimus for AT LEAST 28 consecutive days unless intolerant or the medication is contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
30	Has documentation been submitted to confirm that the patient has had treatment failure with daily use of Zoryve for AT LEAST 56 consecutive days, or is the patient intolerant or the medication contraindicated? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
31	Is the patient greater than or equal to 12 years of age? [If no, no further questions.]	Yes	No
32	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
33	Does the patient have chronic rhinosinusitis with nasal polyposis as evidenced by direct examination, endoscopy, or sinus computed tomography (CT) scan?	Yes	No

PRIOR AUTHORIZATION REQUEST

	ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]		
34	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
35	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? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
36	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
37	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
38	Does the patient have a contraindication to systemic corticosteroid therapy? [If yes, no further questions.]	Yes	No
39	Has the patient had prior surgery for nasal polyps? [If no, no further questions.]	Yes	No
40	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? Note: Dosing is 300 mg every other week. [No further questions.]	Yes	No
41	Is the patient greater than or equal to 1 year of age? [If no, no further questions.]	Yes	No
42	Does the patient weigh 15 kg or more? [If no, no further questions.]	Yes	No
43	Is the requested medication prescribed by or in consultation with an allergist or gastroenterologist? [If no, no further questions.]	Yes	No
44	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? ACTION REQUIRED: Submit supporting documentation.	Yes	No

PRIOR AUTHORIZATION REQUEST

	[If no, no further questions.]		
45	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
46	Has documentation been submitted to confirm that the patient has had a treatment failure with at least 8 weeks of therapy with a proton pump inhibitor or topical (esophageal) corticosteroids (for example, budesonide, or fluticasone)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
47	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
48	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 50.]	Yes	No
49	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
50	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? Note: Dosing is 300 mg once weekly. [No further questions.]	Yes	No
51	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
52	Is the requested medication prescribed by or in consultation with an allergist, immunologist, or dermatologist? [If no, no further questions.]	Yes	No
53	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
54	Has the patient experienced pruritus for 6 weeks or longer? [If no, no further questions.]	Yes	No

PRIOR AUTHORIZATION REQUEST

55	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 57.]	Yes	No
56	Has the secondary cause been adequately managed according to the prescriber? [If no, no further questions.]	Yes	No
57	Has the patient tried at least TWO high- or super-high-potency prescription topical corticosteroid? [If no, no further questions.]	Yes	No
58	Was the topical corticosteroid applied daily for at least 14 consecutive days? [If no, no further questions.]	Yes	No
59	Was inadequate efficacy demonstrated with the topical corticosteroid therapy, according to the prescriber? [If no, no further questions.]	Yes	No
60	Has documentation been submitted to confirm that the patient has had a treatment failure with at least TWO traditional agents for prurigo nodularis for at least 3 months? ACTION REQUIRED: Submit supporting documentation. [Note: Examples include systemic immunosuppressants or topical calcineurin inhibitors.] [If no, no further questions.]	Yes	No
61	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? Note: Dosing is 600 mg once, followed by 300 mg once every other week. [No further questions.]	Yes	No
62	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
63	Is the requested medication being prescribed by or in consultation with an allergist, immunologist, or pulmonologist? [If no, no further questions]	Yes	No
64	Does the patient have a blood eosinophil greater than or equal to 300 cells/microliter within the last 6 weeks prior to treatment with Dupixent or another monoclonal antibody treatment? [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	Yes	No

PRIOR AUTHORIZATION REQUEST

	subcutaneous injection), and Xolair (omalizumab subcutaneous injection).] [If no, no further questions.]		
65	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
66	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
67	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 69.]	Yes	No
68	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
69	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
70	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? Note: Dosing is 300 mg once every other week. [No further questions.]	Yes	No
71	Is the patient greater than or equal to 2 years of age? [If no, no further questions.]	Yes	No
72	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
73	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

PRIOR AUTHORIZATION REQUEST

74	Has the patient been evaluated for skin morbidities and other causes of urticaria? [If no, no further questions]	Yes	No
75	Is the requested medication being prescribed by or in consultation with an allergist, immunologist, or pulmonologist? [If no, no further questions.]	Yes	No
76	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? Note: Dosing: Adults: 600 mg once, followed by 300 mg once every other week; Children: weight-based dosing. [No further questions.]	Yes	No
77	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
78	Has the patient ever been treated with an anti-IL4 or anti-IL13 monoclonal antibody? [If yes, no further questions.]	Yes	No
79	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
80	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
81	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
82	Is the requested medication being prescribed by or in consultation with an allergist, immunologist, or dermatologist? [If no, no further questions.]	Yes	No
83	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? Note: Dosing is 600 mg once, followed by 300 mg once every other week. [No further questions.]	Yes	No
84	Is the patient greater than or equal to 6 years of age? [If no, no further questions.]	Yes	No
85	Has documentation been submitted to show the patient has a diagnosis of allergic fungal rhinosinusitis as evidenced by ALL of the following: A)	Yes	No

PRIOR AUTHORIZATION REQUEST

	Immunoglobulin E (IgE)-mediated inflammatory response to fungal hyphae as evidenced by specific IgE serology or skin test, B) Presence of nasal polyps as evidenced by direct examination, endoscopy, or sinus computed tomography (CT) scan, C) Presence of signs characteristic of allergic fungal rhinosinusitis on CT scan? ACTION REQUIRED: Submit supporting documentation. [Note: Characteristic signs of allergic fungal rhinosinusitis on CT scan may include hyperdensities, bony demineralization, or bone erosion of sinus.] [If no, no further questions.]		
86	Has the patient had at least one prior sino-nasal surgery? [If no, no further questions.]	Yes	No
87	Is the requested medication being prescribed by or in consultation with an allergist, immunologist, otolaryngologist, rhinologist, pulmonologist, or infectious disease specialist? [If no, no further questions.]	Yes	No
88	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? Note: Dosing: Adults: 300 mg once every 2 weeks; pediatric: weight-based dosing.	Yes	No

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.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

If you have any questions, call: 1-888-258-8250