Dupixent (Dupilumab) Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-512-9004.
Provider Help Desk: 1-800-454-3730

1. Patient information	**2. Physician information**
Patient name: ___________________________	Prescribing physician: ___________________________
Patient ID #: ___________________________	Physician address: ___________________________
Patient DOB: ___________________________	Physician phone #: ___________________________
Date of Rx: ___________________________	Physician fax #: ___________________________
Patient phone #: ___________________________	Physician specialty: ___________________________
Patient email address: ___________________________	Physician DEA: ___________________________
	Physician NPI #: ___________________________
	Physician email address: ___________________________

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
________________	________________	________________	Specify: ________________
7. Diagnosis: ________________________________			

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

Prior authorization is required for Dupixent (dupilumab). Payment will be considered under the following conditions:

1. Patient is within the FDA labeled age for indication; and
2. Patient has a diagnosis of moderate-to-severe atopic dermatitis; and
   a. Is prescribed by or in consultation with a dermatologist, allergist, or immunologist; and
   b. Patient has failed to respond to good skin care and regular use of emollients; and
   c. Patient has documentation of an adequate trial and therapy failure with one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; and
   d. Patient has documentation of a previous trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and
   e. Patient has documentation of a previous trial and therapy failure with cyclosporine or azathioprine; and
   f. Patient will continue with skin care regimen and regular use of emollients; or
3. Patient has a diagnosis of moderate to severe asthma with an eosinophilic phenotype (with a pretreatment eosinophil count ≥ 150 cells/mcL within the previous 6 weeks) OR with oral corticosteroid dependent asthma; and
   a. Is prescribed by or in consultation with an allergist, immunologist, or pulmonologist; and
   b. Has a pretreatment forced expiratory volume in 1 second (FEV1) ≤ 80% predicted; and

   c. Symptoms are inadequately controlled with documentation of current treatment with a high-dose inhaled corticosteroid (ICS) given in combination with a controller medication (e.g. long acting beta2 agonist [LABA], leukotriene receptor antagonist [LTRA], oral theophylline) for a minimum of 3 consecutive months. Patient must be compliant with therapy, based on pharmacy claims; and
   d. Patient must have one of the following, in addition to the regular maintenance medications defined above:
      i. 2 or more exacerbations in the previous year, or
      ii. Require daily oral corticosteroids for at least 3 days; and
4. Patient has a diagnosis of inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP); and
   a. Documentation dupilumab will be used as an add-on maintenance treatment; and
   b. Documentation of an adequate trial and therapy failure with at least one preferred medication from each of the following categories:
      i. Nasal corticosteroid spray; and
      ii. Oral corticosteroid; and
5. Dose does not exceed the FDA approved dosing for indication

If criteria for coverage are met, initial authorizations will be given for 16 weeks to assess the response to treatment. Requests for continuation of therapy will require documentation of a positive response to therapy. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

☐ **Moderate-to-Severe Atopic Dermatitis**
Is prescriber a dermatologist, allergist or immunologist?
☐ Yes. Specialty: ____
☐ No. If no, note consultation with dermatologist, allergist, or immunologist:
Consultation date: __________________________ Physician name, specialty and phone: _____________________
____

Did patient fail to respond to good skin care and regular use of emollients?
☐ Yes ☐ No
If yes, provide documentation below:
Provide skin care regimen, including name and dates of emollient use: _______________________________________
____

Will patient continue skin care regimen and regular use of emollients? ☐ Yes ☐ No
Preferred medium to high potency topical corticosteroid trial:
Drug name and dose: ____Trial dates: ________________________
Failure reason: ____
Topical immunomodulator trial:
Drug name and dose: ____Trial dates: __________________________
Failure reason: ____
Cyclosporine or Azathioprine trial:
Drug name and dose: ____Trial dates: _________________________
Failure reason: ____
Medical or contraindication reason to override trial requirements: ____

Moderate-to-Severe Asthma with an Eosinophilic Phenotype
Does patient have pretreatment eosinophil count ≥ 150 cells/mcL within the previous 6 weeks?
☐ Yes (Attach results.) ☐ No

Does patient have oral corticosteroid dependent asthma?
☐ Yes ☐ No
Is prescriber an allergist, immunologist, or pulmonologist?
☐ Yes. Specialty: ______________________________
☐ No. If no, note consultation with allergist, immunologist or pulmonologist:
Consultation date: ______________ Physician name, specialty and phone: ______________
____

Does patient have a pretreatment FEV1 ≤ 80% predicted?
☐ Yes (Attach results.) ☐ No

Document current treatment with a high-dose ICS given in combination with a controller medication:
High-Dose ICS Trial:
Drug name and dose: ______________ Trial dates: ______________
Failure reason: ______________________________
Controller Medication Trial:
Drug name and dose: ______________ Trial dates: ______________
Failure reason: ______________________________

Does patient have one of the following?
Two or more exacerbations in the previous year? ☐ Yes ☐ No

Require daily oral corticosteroids for at least 3 days? ☐ Yes ☐ No

Renewal requests:
Document positive response to therapy: ______________________________
____

Attach lab results and other documentation as necessary.

9. Physician signature

______________________________ ______________
Prescriber or authorized signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. 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.