Hawki Iowa HHS | Iowa Health Link Iowa HHS | Amerigroup

Medicaid | Children's Health Insurance Program

Request for Prior Authorization
Dupilumab (Dupixent)

Contains confidential patient information
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at **844-512-9004.**
Provider Help Desk: **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 for non-preferred agents will be considered when there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered when patient has an FDA approved or compendia indication for the requested drug under the following conditions:

1) Request adheres to all FDA approved labeling for requested drug and indication including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
2) Patient's current weight in kilograms (kg) is provided; and
3) 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
4) 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. Two (2) or more exacerbations in the previous year, or
   ii. Require daily oral corticosteroids for at least 3 days; or

5) 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; or
6) Patient has a diagnosis of eosinophilic esophagitis (EoE); and
   a. Is prescribed by, or in consultation with, and allergist, gastroenterologist, or immunologist; and
   b. Patient has ≥ 15 intraepithelial eosinophils per high-power field (eos/hpf) as confirmed by endoscopic esophageal biopsy (attach results); and
   c. Patient has signs and symptoms of esophageal dysfunction (e.g., dysphagia, food impaction, food refusal, abdominal pain. heartburn regurgitation, chest pain and/or, odynophagia); and
   d. Documentation of previous trials and therapy failures with all of the following:
      i. High dose proton pump inhibitor (PPI) for at least 8 weeks; and
      ii. Swallowed topical corticosteroid (e.g., fluticasone propionate, oral budesonide suspension); and
      iii. Dietary therapy; and
7) Patient has a diagnosis of moderate to severe prurigo nodularis (PN); and
   a. Is prescribed by, or in consultation with an allergist, immunologist, or dermatologist; and
   b. Patient has experienced severe to very severe pruritis, as demonstrated by a current Worst Itch-Numeric Rating Scale (WI-NRS) ≥ 7; and
   c. Patient has ≥ 20 nodular lesions (attach documentation); and
   d. Documentation of a previous trial and therapy failure with a high or super high potency topical corticosteroid for at least 14 consective days; and
8) Dose does not exceed the FDA approved dosing for indication.

If criteria for coverage are met, initial authorizations will be given for 6 months 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.

Non-Preferred

☐ Dupixent

☐ **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 & 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 & dose: _____ Trial dates: _____

Failure reason: _____

Topical immunomodulator trial:

Drug name & dose: _____ Trial dates: _____

Failure reason: _____

Cyclosporine or Azathioprine trial:

Drug name & dose: _____ Trial dates: _____

Failure reason: _____

☐ **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 & phone:

_____

Does patient have a pretreatment FEV_1 ≤ 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 & dose: _____ Trial dates: _____

Failure reason: _____

Controller Medication Trial:

Drug name & dose: _____ Trial dates: _____

Failure reason: _____

Does patient have one of the following?

Two (2) or more exacerbations in the previous year? ☐ Yes ☐ No

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

☐ **Inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP)**

Will dupliumab be used as an add-on maintenance treatment?

☐ Yes (document concomitant maintenance treatment): Drug name & dose: _____

☐ No

Document adequate trial and therapy failure with at least one preferred medication from each of the following categories:

Nasal Corticosteroid Spray Trial:

Drug name & dose: _____ Trial dates: _____

Failure reason: _____

Oral Corticosteroid Trial:

Drug name & dose: _____ Trial dates: _____

Failure reason: _____

☐ **Eosinophilic Esophagitis (EoE)**

☐ Yes specialty: _____
☐ No If no, note consultation with allergist, immunologist, or gastroenterologist:
Consultation date: _____ Physician name, specialty & phone: _____

_____

Does patient have ≥ 15 intraepithelial eosinophils per high-power field (eos/hpf) confirmed by endoscopic esophageal biopsy?

☐ Yes (attach results) ☐ No

Does patient have signs and symptoms of esophageal dysfunction?

☐ Yes, provide signs and symptoms: _____
☐ No

Document previous trials and therapy failures with all of the following:

High Dose PPI :

Drug name & dose: _____ Trial dates: _____

Failure reason: _____

Swallowed topical corticosteroid:

Drug name & dose: _____ Trial dates: _____

Failure reason: _____

Dietary Therapy:

Drug name & dose: _____ Trial dates: _____

Failure reason: _____

Renewal requests:

Document positive response to therapy: _____

_____

Attach lab results and other documentation as necessary.

9. Physician signature

_____ _____

Prescriber or authorized signature Date

***MUST MATCH PRESCRIBER LISTED ABOVE**

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.

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.