



### Request for Prior Authorization Dupilumab (Dupixent)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

- b. Patient has  $\geq 20$  nodular lesions (attach documentation); and
  - c. Documentation of a previous trial and therapy failure with a high or super high potency topical corticosteroid for at least 14 consecutive days; or
- 8) Patient has a diagnosis of chronic obstructive pulmonary disease (COPD) and an eosinophilic phenotype; and
- a. Patient has moderate to severe airflow limitation, measured within the past 12 months, as evidenced by both of the following:
    - i. FEV1/FVC ratio  $< 0.7$ , and
    - ii. FEV1 % predicted between 30% to 79%; and
  - b. Patient has a minimum blood eosinophil count of 300 cells/mcL, measured within the past 12 months; and
  - c. Patient has documentation of maximal inhaled therapy for 3 or more months and an inadequate response to:
    - i. Triple therapy with all of the following treatments:
      - 1. Long-acting muscarinic antagonist/anticholinergic (LAMA); and
      - 2. Long-acting beta agonist (LABA); and
      - 3. Inhaled corticosteroid (ICS); or
    - ii. Double therapy with both of the following if ICS is contraindicated
      - 1. LABA; and
      - 2. LAMA; and
  - d. Patient has history of at least 2 moderate or 1 severe exacerbation(s) in the previous 12 months despite receiving maximal triple therapy or double therapy (defined above). Moderate exacerbation is defined as patient required treatment with systemic corticosteroids and/or antibiotics and severe exacerbation is defined as hospitalization or observation for over 24 hours in an emergency department or urgent care facility; and
  - e. Patient will continue to receive maintenance therapy (as documented above) concomitantly with dupilumab; or
- 9) Patient has a diagnosis of chronic spontaneous urticaria (CSU) with no known cause; and
- a. Patient has documentation of an adequate trial and therapy failure with a preferred second generation H1 receptor antihistamine for at least 2 weeks; or
- 10) Patient has a diagnosis of bullous pemphigoid (BP); and
- a. Is initiated with a tapering course of oral corticosteroids; or
- 11) Patient has a diagnosis of allergic fungal rhinosinusitis (AFRS); and
- a. Patient has a history of sino-nasal surgery.

If criteria for coverage are met, initial authorizations will be given for 6 months for all the above indications, except COPD, CSU BP, and AFRS which will receive an initial authorization of 12 months to assess the response to treatment. Requests for continuation of therapy will require documentation of a positive response to therapy and continued use of add-on maintenance therapy, where indicated.

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

**Preferred**

Dupixent

Strength	Usage Instructions	Quantity	Day's Supply
_____	_____	_____	_____

Diagnosis: \_\_\_\_\_

Patient's current weight in kg: \_\_\_\_\_ Date obtained: \_\_\_\_\_

Moderate-to-Severe Atopic Dermatitis

Did patient fail to respond to good skin care and regular use of emollients?

Yes  No If yes, provide documentation below:



Fax Completed Form To  
1.833.404.2392

Prescriber Help Desk  
1.833.587.2012

Online

[covermymeds.com/main/  
prior-authorization-forms/](http://covermymeds.com/main/prior-authorization-forms/)

**Request for Prior Authorization**

**Dupilumab (Dupixent)**

(PLEASE PRINT – ACCURACY IS IMPORTANT)

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: \_\_\_\_\_

**Moderate-to-Severe Asthma with an Eosinophilic Phenotype**

**Does patient have pretreatment eosinophil count  $\geq$  150 cells/mcL within the previous 6 weeks?**

Yes (attach results)  No

**Does patient have oral corticosteroid dependent asthma?**

Yes  No

Provide pretreatment FEV<sub>1</sub> % predicted (attach results): \_\_\_\_\_

**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?**

One (1) 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 dupilumab 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: \_\_\_\_\_



Fax Completed Form To  
1.833.404.2392

Prescriber Help Desk  
1.833.587.2012

Online

[covermymeds.com/main/prior-authorization-forms/](http://covermymeds.com/main/prior-authorization-forms/)

### Request for Prior Authorization Dupilumab (Dupixent)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Failure reason: \_\_\_\_\_

#### Oral Corticosteroid Trial:

Drug name & dose: \_\_\_\_\_ Trial dates: \_\_\_\_\_

Failure reason: \_\_\_\_\_

#### Eosinophilic Esophagitis (EoE)

Does patient have  $\geq 15$  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:

Dietary Plan: \_\_\_\_\_ Trial dates: \_\_\_\_\_

Failure reason: \_\_\_\_\_

#### Moderate to Severe Prurigo Nodularis (PN)

Worst Itch-Numeric Rating Scale (WI-NRS) response: \_\_\_\_\_ Date obtained: \_\_\_\_\_

Does patient have  $\geq 20$  nodular lesions?  Yes (provide documentation)       No

Preferred high or super high potency topical corticosteroid trial:

Drug name & dose: \_\_\_\_\_ Trial dates: \_\_\_\_\_

Failure reason: \_\_\_\_\_

#### Chronic Obstructive Pulmonary Disease (COPD) and an eosinophilic phenotype:

Provide all of the following information:

FEV1/FVC ratio: \_\_\_\_\_ Date obtained: \_\_\_\_\_

FEV1 % predicted: \_\_\_\_\_ Date obtained: \_\_\_\_\_

Blood eosinophil count: \_\_\_\_\_ Date obtained: \_\_\_\_\_

**Request for Prior Authorization  
Dupilumab (Dupixent)**

(PLEASE PRINT – ACCURACY IS IMPORTANT)

**Trial information:****LABA Trial:**

Name/dose: \_\_\_\_\_ Trial dates: \_\_\_\_\_

Failure reason/medical contraindication: \_\_\_\_\_

**LAMA Trial:**

Name/dose: \_\_\_\_\_ Trial dates: \_\_\_\_\_

Failure reason/medical contraindication: \_\_\_\_\_

**ICS Trial:**

Name/dose: \_\_\_\_\_ Trial dates: \_\_\_\_\_

Failure reason/medical contraindication: \_\_\_\_\_

**Document exacerbations:****Moderate:**

Date: \_\_\_\_\_ Treatment needed: \_\_\_\_\_

Date: \_\_\_\_\_ Treatment needed: \_\_\_\_\_

**Severe:**

Date: \_\_\_\_\_ Place of care: \_\_\_\_\_

Will patient continue to receive maintenance therapy concomitantly with dupilumab?  Yes  No **Chronic Spontaneous Urticaria (CSU)****H1 receptor antihistamine trial:**

Name/dose: \_\_\_\_\_ Trial dates: \_\_\_\_\_

Failure reason/medical contraindication: \_\_\_\_\_

 **Bullous Pemphigoid (BP)****Tapering course of oral corticosteroid:**

Drug name &amp; dose: \_\_\_\_\_ Start date: \_\_\_\_\_

 **Allergic Fungal Rhinosinusitis (AFRS)**Has patient had sino-nasal surgery?  Yes; provide date: \_\_\_\_\_  No**Renewal requests:**

Document positive response to therapy: \_\_\_\_\_

Is add-on maintenance therapy currently being used, if applicable?  Yes  No**Attach lab results and other documentation as necessary.**

Prescriber signature (Must match prescriber listed above.)	Date of submission
--	--------------------

**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 Health and Human Services, that the member continues to be eligible for Medicaid.