

Dupilixent® (Dupilumab) Prior Authorization Form

Member Name: _____ Date of Birth: _____ Member ID#: _____

Drug Information

Pharmacy billing (NDC: _____) Fill Date: _____

Dose: _____ Regimen: _____

Pharmacy Information

Pharmacy NPI: _____ Pharmacy Name: _____

Pharmacy Phone: _____ Pharmacy Fax: _____

Prescriber Information

Prescriber NPI: _____ Prescriber Name: _____

Prescriber Phone: _____ Prescriber Fax: _____ Specialty: _____

Clinical Information

For Initial Authorization: (Page 1 of 5—please complete and return ALL pages)

1. Please indicate diagnosis:
 - Chronic Spontaneous Urticaria (CSU)
 - Eosinophilic Esophagitis (EoE)
 - Prurigo Nodularis (PN)
 - Bullous Pemphigoid (BP)
 - Moderate-to-Severe Atopic Dermatitis
 - Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP)
 - Chronic Obstructive Pulmonary Disease (COPD)
 - Moderate-to-Severe Eosinophilic Phenotype Asthma
 - Oral Corticosteroid-Dependent Asthma
 - Other, please list: _____

A. Has the member been counseled on proper administration and storage of Dupilixent®? Yes ___ No ___

B. Has the member been evaluated by an allergist, gastroenterologist, dermatologist, immunologist, otolaryngologist, pulmonologist, pulmonary specialist within the last 12 months (or an advanced care practitioner with a supervising physician who is one of these specialties)? Yes ___ No ___

i. If yes, please include name of specialist: _____ Specialty: _____

C. Will the member be using Dupilixent® concurrently with other biologic medications? Yes ___ No ___

i. If yes, please provide patient-specific information to support the concurrent use of both medications: _____

D. What is the member's weight? _____

2. If diagnosis is **Chronic Spontaneous Urticaria (CSU)**, please provide the following (*Initial approvals will be for the duration of 6 months*):
 - A. Have other forms of urticaria been ruled out? Yes ___ No ___
 - B. Have other potential causes of urticaria been ruled out? Yes ___ No ___
 - C. Member's Urticaria Activity Score (UAS): _____ Date assessed: _____
 - D. Does member have a trial of a second-generation H1 antihistamine dosed 4 times the maximum FDA dose within the last 3 months?? Yes ___ No ___
 - i. If "Yes", please provide the medication used, dose prescribed, and dates of use:
Medication: _____ Dose: _____ Dates of use: _____
 - ii. If the second generation H1 antihistamine trial duration was less than 4 weeks, please provide a reason why a 4-week trial is not appropriate for this member: _____
 - E. A patient-specific, clinically significant reason why the member cannot use Xolair®: _____

(Page 1 of 5)

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:
University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit
Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

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Page 2 of 5—Please complete and return all pages. Failure to complete all pages will result in processing delays.

3. If diagnosis is **Eosinophilic Esophagitis (EoE)**, please provide the following (*Initial approvals will be for the duration of 6 months*):
- A. Does the member have the presence of clinical symptoms of EoE ≥ 2 times per week (i.e., dysphagia, emesis, epigastric pain)? Yes ___ No ___
 - B. Does the member have intraepithelial eosinophilia [≥ 15 eosinophils per high-power field (eol/hpf) in the esophagus]? Yes ___ No ___
 - C. Has the member failed 1 high-dose proton pump inhibitor?
Yes ___ No ___
 - i. If yes, please provide the medication and duration of treatment:
 - a. Drug: _____ Date of trial: _____
 - b. Was the trial at least 8 weeks in duration? Yes ___ No ___
 - ii. If no, is there a contraindication or documented intolerance to high-dose proton pump inhibitors?
Yes ___ No ___
 - a. If yes, please describe: _____
 - D. Has the member failed 1 swallowed inhaled respiratory corticosteroid (e.g. budesonide)?
Yes ___ No ___
 - i. If yes, please provide the medication and duration of treatment:
 - a. Drug: _____ Date of trial: _____
 - b. Was the trial at least 8 weeks in duration? Yes ___ No ___
 - ii. If no, is there a contraindication or documented intolerance to swallowed inhaled respiratory corticosteroids? Yes ___ No ___
 - a. If yes, please describe: _____
4. If diagnosis is **Prurigo Nodularis (PN)**, please provide the following (*Initial approvals will be for the duration of 6 months*):
- A. Has the member had a diagnosis of PN for at least 3 months? Yes ___ No ___
 - B. Does the member have a Worst-Itch Numeric Rating Scale (WI-NRS) score of ≥ 7 ? Yes ___ No ___
 - C. Does the member have ≥ 20 PN lesions? Yes ___ No ___
 - D. Has the prescriber ruled out all other causes of pruritis? Yes ___ No ___
 - E. Has the member failed 1 medium potency to very-high potency Tier-1 topical corticosteroid?
Yes ___ No ___
 - i. If yes, please provide the medication and duration of treatment:
 - a. Drug: _____ Date of trial: _____
 - b. Was the trial at least 2 weeks in duration? Yes ___ No ___
 - ii. If no, is there a contraindication or documented intolerance to medium potency to very-high potency Tier-1 topical corticosteroids? Yes ___ No ___
 - a. If yes, please describe: _____
 - F. Has the member failed 1 topical calcineurin inhibitor [e.g., Elidel® (pimecrolimus), Protopic® (tacrolimus)]?
Yes ___ No ___
 - i. If yes, please provide the medication and duration of treatment:
 - a. Drug: _____ Date of trial: _____
 - b. Was the trial at least 2 weeks in duration? Yes ___ No ___
 - ii. If no, is there a contraindication or documented intolerance to topical calcineurin inhibitors?
Yes ___ No ___
 - a. If yes, please describe: _____

(Page 2 of 5)

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Page 3 of 5—Please complete and return all pages. Failure to complete all pages will result in processing delays.

5. If diagnosis is **Bullous Pemphigoid (BP)**, please provide the following (*Initial approvals will be for the duration of 6 months*):
- A. Have all other potential causes and/or diagnoses with a similar presentation to BP been ruled out?
Yes ___ No ___
 - B. Member's Bullous Pemphigoid Disease Area Index (BPDAI) activity score: _____
 - C. Member's Worst-Itch Numeric Rating Scale (WI-NRS) score: _____
 - D. Will member be using dupilumab in combination with a tapering course of oral corticosteroids as outlined in the package labeling? Yes ___ No ___
 - i. If no, is there a contraindication or documented intolerance? Yes ___ No ___
 - a. If yes, please describe: _____
 - E. Has the member failed a medium potency to very-high potency topical corticosteroid? Yes ___ No ___
 - i. If yes, please provide the medication and duration of treatment:
 - a. Drug: _____ Date of trial: _____
 - b. Was the trial at least 2 weeks in duration? Yes ___ No ___
 - ii. If no, is there a contraindication or documented intolerance to topical corticosteroids? Yes ___ No ___
 - a. If yes, please describe: _____
 - F. Has the member failed an oral corticosteroid? Yes ___ No ___
 - i. If yes, please provide the medication and duration of treatment:
 - a. Drug: _____ Date of trial: _____
 - b. Was the trial at least 2 weeks in duration? Yes ___ No ___
 - ii. If no, is there a contraindication or documented intolerance to oral corticosteroids? Yes ___ No ___
 - a. If yes, please describe: _____
 - G. Has the member failed an immunosuppressive agent (e.g., methotrexate, azathioprine, mycophenolate, cyclophosphamide)? Yes ___ No ___
 - i. If yes, please provide the medication and duration of treatment:
 - a. Drug: _____ Date of trial: _____
 - b. Was the trial at least 2 weeks in duration? Yes ___ No ___
 - ii. If no, is there a contraindication or documented intolerance to immunosuppressive agents?
Yes ___ No ___
 - a. If yes, please describe: _____
 - H. Has the member failed an oral antibiotic agent (e.g., doxycycline, dapsone)? Yes ___ No ___
 - i. If yes, please provide the medication and duration of treatment:
 - a. Drug: _____ Date of trial: _____
 - b. Was the trial at least 2 weeks in duration? Yes ___ No ___
 - ii. If no, is there a contraindication or documented intolerance to oral antibiotic agents? Yes ___ No ___
 - a. If yes, please describe: _____

(Page 3 of 5)

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Page 4 of 5—Please complete and return all pages. Failure to complete all pages will result in processing delays.

6. If diagnosis is **Moderate-to-Severe Atopic Dermatitis**, please provide the following (*Initial approvals will be for the duration of 16 weeks*):
- A. Is member inadequately controlled with topical prescription therapies? Yes ___ No ___
 - B. Member's body surface area (BSA) of atopic dermatitis involvement: _____
 - C. Please provide a patient-specific, clinically significant reason why the member cannot use Adbry®:

 - D. Has the member failed 1 medium potency to very-high potency Tier-1 topical corticosteroid?
Yes ___ No ___
 - i. If yes, please provide the medication and duration of treatment:
 - a. Drug: _____ Date of trial: _____
 - b. Was the trial at least 2 weeks in duration? Yes ___ No ___
 - ii. If no, is there a contraindication or documented intolerance to medium potency to very-high potency Tier-1 topical corticosteroids? Yes ___ No ___
 - a. If yes, please describe: _____
 - E. Has the member failed 1 topical calcineurin inhibitor [e.g., Elidel® (pimecrolimus), Protopic® (tacrolimus)]?
Yes ___ No ___
 - i. If yes, please provide the medication and duration of treatment:
 - a. Drug: _____ Date of trial: _____
 - b. Was the trial at least 2 weeks in duration? Yes ___ No ___
 - ii. If no, is there a contraindication or documented intolerance to topical calcineurin inhibitors?
Yes ___ No ___
 - a. If yes, please describe: _____
7. If diagnosis is **Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP)**, please provide the following (*Initial approvals will be for the duration of 6 months*):
- A. Will Dupilixent® be used as add-on maintenance treatment for inadequately controlled CRSwNP?
Yes ___ No ___
 - B. Does the member have a trial with intranasal corticosteroid that resulted in failure (or have a contraindication or documented intolerance)? Yes ___ No ___
 - i. If yes, please provide the medication used and dates of use: _____
 - C. Has the member required prior sino-nasal surgery? Yes ___ No ___
 - D. Has the member been treated with systemic corticosteroids for CRSwNP in the past 2 years (or have a contraindication or documented intolerance)? Yes ___ No ___
 - E. Does the member have symptoms of chronic rhinosinusitis (e.g., facial pain/pressure, reduction or loss of smell, nasal blockade/obstruction/congestion, nasal discharge) for 12 weeks or longer despite attempts at medical management? Yes ___ No ___
 - F. Does the member have evidence of nasal polyposis by direct examination, sinus CT scan, or endoscopy?
Yes ___ No ___
 - G. Will the member continue to receive intranasal corticosteroid therapy? Yes ___ No ___
 - i. If no, does the member have a contraindication to intranasal corticosteroid therapy? Yes ___ No ___
 - 1. If yes, please provide the member's contraindication: _____

(Page 4 of 5)

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Page 5 of 5—Please complete and return all pages. Failure to complete all pages will result in processing delays.

8. If diagnosis is **Chronic Obstructive Pulmonary Disease (COPD)**, please provide the following (*Initial approvals will be for the duration of 6 months*):
- A. Will Dupilixent® be used as add-on maintenance treatment for inadequately controlled COPD?
Yes _____ No _____
 - B. Does member have moderate to severe disease [i.e., GOLD 2 or GOLD 3 airflow obstruction as demonstrated by forced expiratory volume in 1 second (FEV1) ≥30% and <80% predicted]? Yes _____ No _____
 - C. Is member symptomatic [i.e., modified Medical Research Council (mMRC) dyspnea scale grade ≥2]?
Yes _____ No _____
 - D. Blood eosinophil count: _____ Date Determined: _____
 - E. Has member experienced ≥2 moderate exacerbations (e.g., required treatment with systemic corticosteroids and/or antibiotics or ≥1 severe exacerbation (e.g., required hospitalization or 24-hour observation in emergency room or urgent care) in the last 12 months? Yes _____ No _____
 - i. If yes, please provide dates of exacerbations: _____
 - F. Is member inadequately controlled on triple therapy combination (LABA/LAMA/ICS) used compliantly within the last 3-6 consecutive months? Yes _____ No _____
 - i. If yes, please provide drug/dose: _____
 - ii. If no, is there a contraindication? Yes _____ No _____
 - a. If yes, please provide details: _____

9. If diagnosis is **Moderate-to-Severe Eosinophilic Phenotype Asthma or Oral Corticosteroid-Dependent Asthma**, please provide the following (*Initial approvals will be for the duration of 6 months*):
- A. Will this medication be used as add-on maintenance treatment? Yes _____ No _____
 - i. If yes, please indicate member's daily medications and dose prescribed for treatment of this diagnosis:
Drug/Dose: _____ Drug/Dose: _____
 - B. Baseline blood eosinophil count: _____ Date Determined: _____
 - C. Does member require daily systemic corticosteroids despite compliant use of high-dose inhaled corticosteroid (ICS) plus at least one additional controller medication? Yes _____ No _____
 - i. If no, please list number and dates of exacerbations requiring systemic corticosteroids within last 12 months: Number: _____ Dates of exacerbations: _____
 - D. Please check all that apply:
 - Member has failed a medium to high-dose ICS used compliantly within the last 3-6 consecutive months.
- Drug/Dose: _____
 - Member has failed at least 1 other asthma controller medication used in addition to the medium to high-dose ICS compliantly for at least the past 3 months.
- Drug/Dose: _____

For Continued Authorization:

- 1. Is member compliant with therapy? Yes _____ No _____
- 2. Is member responding well to therapy? Yes _____ No _____
- 3. If member's diagnosis includes Chronic Spontaneous Urticaria, please provide member's current Urticaria Activity Score (UAS): _____ Date assessed: _____
 - a. If there has been no improvement in member's UAS score, please provide additional clinical information to support the continuation of Dupilixent® treatment: _____

(Page 5 of 5)

Prescriber Signature: _____ **Date:** _____

By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.

Please do not send in chart notes. Specific information/documentation will be requested if necessary. Please complete and return all pages. Failure to complete all pages will result in processing delays.

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