

**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)
- Allergic Fungal Rhinosinusitis (AFRS)
- 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. Member's Urticaria Activity Score (UAS): \_\_\_\_\_ Date assessed: \_\_\_\_\_

C. 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: \_\_\_\_\_

(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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**Dupilent® (Dupilumab) Prior Authorization Form**

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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  $\geq 2$  times per week (i.e., dysphagia, emesis, epigastric pain)? Yes \_\_\_ No \_\_\_
  - B. Does the member have intraepithelial eosinophilia [ $\geq 15$  eosinophils per high-power field (eol/hpf) in the esophagus]? Yes \_\_\_ No \_\_\_
  - C. Has the member failed 1 high-dose proton pump inhibitor or 1 swallowed 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 high-dose proton pump inhibitors or swallowed 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  $\geq 7$ ? Yes \_\_\_ No \_\_\_
  - C. Does the member have  $\geq 20$  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: \_\_\_\_\_
5. If diagnosis is **Allergic Fungal Rhinosinusitis (AFRS)**, please provide the following (*Initial approvals will be for the duration of 6 months*):
- A. Does member have any of the following? (*check all that apply*)
    - Evidence of sinus opacification
    - Evidence of nasal polyposis
    - IgE mediated inflammatory response to fungus or sensitization to fungus
    - Eosinophilic mucus
    - Characteristic CT signs of AFRS (i.e. hyperdensities, bone erosion of sinus, bony demineralization)
  - B. Has member required prior sino-nasal surgery? Yes \_\_\_ No \_\_\_
  - C. Does member have fungal invasive sinusitis? Yes \_\_\_ No \_\_\_

*(Page 2 of 5 - AFRS continued on next page)*

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5. If diagnosis is **Allergic Fungal Rhinosinusitis (AFRS)**, please provide the following (*continued from previous page*):
- D. Has the member failed an intranasal or systemic corticosteroid Yes \_\_\_ No \_\_\_
    - i. If yes, please provide the medication and duration of treatment:
      - a. Drug: \_\_\_\_\_ Date of trial: \_\_\_\_\_
    - ii. If no, is there a contraindication or documented intolerance? Yes \_\_\_ No \_\_\_
      - a. If yes, please describe: \_\_\_\_\_
6. 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, dapson)? 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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7. 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. 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: \_\_\_\_\_
  - D. 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: \_\_\_\_\_
8. 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 \_\_\_
      - a. If yes, please provide the member's contraindication: \_\_\_\_\_

**(Page 4 of 5)**

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9. If diagnosis is **Chronic Obstructive Pulmonary Disease (COPD)**, please provide the following (*Initial approvals will be for the duration of 6 months*):
- A. Will Dupixent® be used as add-on maintenance treatment for inadequately controlled COPD? Yes \_\_\_ No \_\_\_
  - B. Is member symptomatic [i.e., modified Medical Research Council (mMRC) dyspnea scale grade  $\geq 2$ , COPD Assessment Test (CAT)  $\geq 10$ ]? Yes \_\_\_ No \_\_\_
  - C. Blood eosinophil count: \_\_\_\_\_ Date Determined: \_\_\_\_\_
  - D. Has member experienced  $\geq 2$  moderate exacerbations (e.g., required treatment with systemic corticosteroids and/or antibiotics or  $\geq 1$  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: \_\_\_\_\_
  - E. 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: \_\_\_\_\_
10. 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 Dupixent® 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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