Dupixent (dupilumab)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTER (if different than prescriber):	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** **IF RENEWAL:** DATE THERAPY INITIATED: DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ **YES** (if yes, complete below) ☐ **NO**		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ **Moderate to severe atopic dermatitis** ☐ **Moderate-to-severe persistent asthma** ☐ **Chronic rhinosinusitis with nasal polyps** ☐ **Eosinophilic Esophagitis** ☐ **Prurigo nodularis** ☐ **Chronic obstructive pulmonary disease** ☐ **Chroni spontaneous urticaria** ☐ Other diagnosis: _____ ICD-10 Code(s):	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Is patient going to be using drug in combination with a clinical trial? ☐ **Yes** ☐ **No**

Is prescriber one of the following or in consultation with one of the following: ? □ **Yes** □ **No** ***Please provide documentation.***
□ **Allergist**
□ **Immunologist**
□ **Dermatologist**
□ **Pulmonologist**
□ **Otolaryngologist**
□ **Gastroenterologist**

Will patient use Dupixent in combination with one of the following? □ **Yes** □ **No**
□ **Nucala(mepolizumab), Cinqair (resilizumab), Fasenra (benralizumab), Xolair(omalizmab), Benlysta(bemlimumab), Nemluvio(nemolizumab-ilto),or Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]**

Will Dupixent(dupilumab) be used in combination with Cibinqo(abrocitinib), Olumiant(baracitinib), RinvoqER(upadacitinib) ,Opzelura(ruxolitinib) or Adbry(tralokinumab)? □ **Yes** □ **No**

<u>For Initial Request of Atopic Dermatitis</u>, answer the following:

Has the patient had the diagnosis of atopic dermatitis for at least 12 months? □ **Yes** □ **No** ***Please submit documentation.***

Does the patient have atopic dermatitis on at least 10% or more of their body surface area? □ **Yes** □ **No** ***Please submit documentation.***

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Has the patient tried at least two different topical steroids? □ Yes □ No *Please submit documentation.*

If patient has not had at least 2 different topical steroids, has the patient tried at least one topical steroid AND one topical calcineurin inhibitor (tacrolimus or pimecrolimus)? □ Yes □ No *Please submit documentation.*

If patient has not had at least 2 different topical steroids, has the patient tried at least one topical steroid AND Eucrisa(crisaborole)? □ Yes □ No *Please submit documentation.*

If patient has not had at least 2 different topical steroids, has the patient tried at least one topical steroid AND Zoryve(roflumilast)? □ Yes □ No *Please submit documentation.*

If patient has not had at least 2 different topical steroids, has the patient tried at least one topical steroid AND Vtama(tapinarof)? □ Yes □ No *Please submit documentation.*

For Renewal of Atopic Dermatitis:

Does patient continue to demonstrate a positive clinical response? □ Yes □ No *Please submit documentation.*

Is prescriber a dermatologist or allergist? □ Yes □ No

Will Dupixent(dupilumab) be used in combo w Cibinqo(abrocitinib), Olumiant(baracitinib), RinvoqER(upadacitinib), Opzelura(ruxolitinib), or Adbry(tralokinumab)? □ Yes □ No

For diagnosis of Moderate-to-severe persistent asthma, answer the following:

Has the patient had moderate to severe persistent asthma for at least one year? □ Yes □ No

Is patient's asthma characterized as corticosteroid dependent asthma? □ Yes □ No

Is patient's asthma characterized as eosinophilic phenotype asthma? □ Yes □ No

Does the patient have COPD or other concurrent lung disease? □ Yes □ No

Is the patient a current smoker? □ Yes □ No

Has the patient quit smoking in the last 6 months? □ Yes □ No

Is the patient a former smoker with a smoking history of more than 10 pack years? □ Yes □ No

Has the patient ever had one of the following:
a.) Blood eosinophil count = 150mcL or greater ? □ Yes □ No *Please submit documentation*
b.) Sputum eosinophil count = 3% or greater ? □ Yes □ No *Please submit documentation*

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Has the patient been on stable medium-to- high dose of an inhaled glucocorticoid (i.e. fluticasone 250 mcg or greater) for at least ONE month? □ Yes □ No *Please submit chart notes*
Has the patient been on stable daily dose of inhaled long-acting beta agonist (i.e salmeterol 50 mcg or greater twice daily) for at least ONE month? □ Yes □ No *Please submit chart notes*

Has the patient received at least ONE systemic (oral or parenteral) steroid burst for worsening asthma, in the past 2 years? □ Yes □ No

Has the patient been hospitalized or visited an emergency care center at least once for worsening asthma, in the past 2 years? □ Yes □ No

Has the patient been receiving regular MAINTENANCE systemic corticosteroids in the past 6 months? □ Yes □ No

Has the patient been receiving oral prednisone or prednisolone at a dose of 5-35 mg per day, or equipotent steroid equivalent for the past 4 weeks? □ Yes □ No *Please submit chart notes*

Has the patient been using high dose inhaled fluticasone at a stable dose >500 mcg per day, or equipotent steroid equivalent for the past 4 months? □ Yes □ No *Please submit chart notes*

Has the patient been using one of the following long-acting beta2 agonist AND/OR leukotriene-receptor antagonist for the past 3 months? □ Yes □ No

For diagnosis of chronic rhinosinusitis with nasal polyps, answer the following:
Does patient have at least a 2 month use of a nasal steroid? □ Yes □ No *Please submit documentation.*

For diagnosis of Eosinophilic Esophagitis, please answer the following:
Has patient had a previous trial with a proton-pump inhibitor(PPI)? □ Yes □ No *Please submit documentation.*
Has patient had a 12 week trial and failure with Eohilia(budesonide oral suspension)? □ Yes □ No *Please submit documentation.*
Does patient have symptoms of dysphagia? □ Yes □ No
Does patient have greater than or equal to 15 (eos/hpf) intraepithelial eosinophils/ high-power field (eos/hpf)? (lab report. □ Yes □ No *Please submit documentation.*
Does the patient have other causes of esophagitis? □ Yes □ No

For diagnosis of Prurigo Nodularis, please answer the following:
Has patient had chronic pruritus lasting ≥6 weeks? □ Yes □ No *Please submit documentation.*

Does patient have history and/or signs of repeated scratching, picking, or rubbing (eg, excoriations and scars)? □ Yes □ No *Please submit documentation.*

Does patient have presence of multiple pruriginous lesions, including firm nodules? □ Yes □ No *Please submit documentation.*

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Has the patient tried at least 2 different medium-to-super-potent topical steroids? □ Yes □ No ***Please submit documentation.***

Has the patient tried at least one medium-to-super-potent topical steroid AND one topical calcineurin inhibitor (tacrolimus or pimecrolimus)? □ Yes □ No ***Please submit documentation.***

Has the patient tried oral psoralen in combination with phototherapy AND at least one medium-to-super-potent topical steroid? □ Yes □ No ***Please submit documentation.***

Has patient tried excimer laser AND at least one medium-to-super-potent topical steroid? □ Yes □ No ***Please submit documentation.***
Has patient tried cryotherapy AND intralesional steroids? □ Yes □ No ***Please submit documentation.***
Has patient tried at least one oral DMARD such as methotrexate or cyclosporine? □ Yes □ No ***Please submit documentation.***

<u>For diagnosis of Chronic obstructive pulmonary disease(COPD), answer the following:</u>
Does patient have a diagnosis of moderate to severe chronic obstructive pulmonary disease(COPD) and an eosinophilic phenotype? ☐ Yes ☐ No (Please provide documentation)

Has patient had COPD for at least 12months? ☐ Yes ☐ No (Please provide documentation)

Has patient been on a stable regimen for at least 3months prior to starting Dupixent(dupilumab) with triple inhaler medications including an inhaled corticosteroid(ICS), a long-acting beta agonist(LABA) inhaler and a long-acting muscarinic antagonist(LAMA) inhaler? ☐ Yes ☐ No (Please provide documentation)

If patient has an absolute contraindication to an inhaled corticosteroid(ICS), then has patient been on a stable regimen for at least 3 months prior to starting Dupixent(dupilumab) with a long-acting beta agonist inhaler(LABA) and a long-acting muscarinic antagonist inhaler(LAMA)? ☐ Yes ☐ No (Please provide documentation)

Is patient a current or former smoker with a smoking history of greater than or equal to 10pack years? ☐ Yes ☐ No (Please provide documentation)

Does patient have a post-bronchodilator FEV1/forced vital capacity[FVC] ratio <0.70? ☐ Yes ☐ No (Please provide documentation)

Does patient have a post-bronchodilator FEV1 %predicted >30% and ≤70%?☐ Yes ☐ No (Please provide documentation)

Does patient have a history of signs and symptoms of chronic bronchitis(chronic productive cough) for 3 months in the absence of other known causes of cough? ☐ Yes ☐ No (Please provide documentation)

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Does patient have blood eosinophils greater than or equal to 300 cells/microliter? ☐ Yes ☐ No (Please provide documentation)

Is patient a high exacerbation risk with a history of 2 or greater moderate exacerbations or 1 or greater severe exacerbations within the previous 12 months prior to starting Dupixent(dupilumab)? ☐ Yes ☐ No (Please provide documentation)
Has at least one exacerbation occurred while the patient was taking an inhaled corticosteroid(ICS)/Long-acting beta agonist(LABA/Long-acting muscarinic antagonist(LAMA) or LABA/LAMA, if the ICS was contraindicated? ☐ Yes ☐ No (Please provide documentation)

Has moderate exacerbations required either systemic corticosteroids(IM, IV or oral) and/or antibiotics? ☐ Yes ☐ No (Please provide documentation)

Has severe exacerbations required hospitalization or greater than 24hour observation in the ER or Urgent Care facility? ☐ Yes ☐ No (Please provide documentation)

Does patient have a diagnosis of asthma or a history of asthma? ☐ Yes ☐ No (Please provide documentation)

Does patient have significant pulmonary disease other than COPD with eosinophilia phenotype such as lung fibrosis, sacroidosis, interstitial lung disease, pulmonary hypertension, bronchiectasis, Churg-Strauss Syndrome or another diagnosed pulmonary or systemic disease associated with elevated peripheral eosinophil counts? ☐ Yes ☐ No (Please provide documentation)

Does patient have right sided heart failure? ☐ Yes ☐ No (Please provide documentation)

Does patient require oxygen of more than 12 hours per day? ☐ Yes ☐ No (Please provide documentation)

Does patient have alpha 1 anti-trypsin deficiency? ☐ Yes ☐ No (Please provide documentation)

<u>Initial Request for Chronic idiopathic urticaria(CIU) or Chronic spontaneous urticaria(CSU):</u>

Have all other causes of urticaria(hives) such as allergies have been ruled out? ☐ Yes ☐ No (Please provide documentation)

Has patient had chronic idiopathic urticaria or chronic spontaneous urticaria for at least 6 weeks or more? ☐ Yes ☐ No (Please provide documentation)

Has patient tried and failed an antihistamine (H1 blocker) such as loratadine, cetirizine, diphenhydramine, and/or hydroxyzine? ☐ Yes ☐ No (Please provide documentation)

Has patient tried and failed a Histamine- 2 blocker such as ranitidine, famotidine, cimetidine, and/or nizatidine? ☐ Yes ☐ No (Please provide documentation)

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Renewal Request for Chronic idiopathic urticaria(CIU) or Chronic spontaneous urticaria(CSU:

Has patient demonstrated a reduction in severity of their disease/symptoms? ☐ Yes ☐ No (Please provide documentation)

Is patient continuing to have clinical disease? ☐ Yes ☐ No (Please provide documentation)

Is patient receiving Xolair in combination with any of the following? ☐ Yes ☐ No
□ Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
□ Anti-interleukin 5 therapy [e.g., Nucala (mepolizumab), Cinqair (resilizumab), Fasenra (benralizumab)]
□ Anti-interleukin 31 therapy[e.g. Nemluvio(nemolizumab-ilto)
□ Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

Initial Request for Bullous Pemphigoid:

Does the patient have a confirmed diagnosis of bullous pemphigoid (BP) by biopsy, blood test and/or immunofluorescence? ☐ Yes ☐ No (Please provide documentation)

Have forms of bullous pemphigoid other than classic BP (eg, Brunsting-Perry cicatricial pemphigoid, anti-p200 pemphigoid, epidermolysis bullosa acquisita, or BP with concomitant pemphigus vulgaris) have been ruled out? ☐ Yes ☐ No (Please provide documentation)

Has patient recently started on treatments known to cause or exacerbate BP (eg, angiotensin converting enzyme inhibitors, penicillamine, furosemide, phenacetin, dipeptidyl peptidase 4 inhibitor) less than 4 weeks before starting on Dupixent(dupilumab)? ☐ Yes ☐ No (Please provide documentation)

Has patient received prior treatment with an IL-4 or IL-13 antagonist such as Dupixent(dupilumab), Adbry(tralokinumab), or Ebglyss(lebrikizumab) for bullous pemphigoid? ☐ Yes ☐ No (Please provide documentation)

Has patient tried at least 2 other treatments for their BP such as topical corticosteroids, topical calcineurin inhibitors, oral corticosteroids, dapsone, doxycycline, azathioprine, rituximab, mycophenolate and/or methotrexate? ☐ Yes ☐ No (Please provide documentation)

Renewal Request for Bullous Pemphigoid:

Has patient demonstrated a reduction in severity of their disease/symptoms? ☐ Yes ☐ No (Please provide documentation)

Is patient continuing to have clinical disease? ☐ Yes ☐ No (Please provide documentation)
Is patient taking any other biologic in combination with Dupixent(dupilumab)? ☐ Yes ☐ No (Please provide documentation)

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP-4201
P.O. Box 64811
St. Paul, MN 55164-0811
Phone: 877-228-7909