

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:
<input type="checkbox"/> NEW THERAPY <input type="checkbox"/> RENEWAL IF RENEWAL: DATE THERAPY INITIATED:			
DURATION OF THERAPY (SPECIFIC DATES):			

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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
- Chronic spontaneous urticaria
- Allergic fungal rhinosinusitis
- 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 (reslizumab), Fasena (benralizumab), Xolair(omalizumab), 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

For Initial Request of Atopic Dermatitis, answer the following:

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

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

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*

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b.) Sputum eosinophil count = 3% or greater ? Yes No **Please submit documentation*

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.*

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

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.

For diagnosis of Chronic obstructive pulmonary disease(COPD), answer the following:

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)

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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)

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, sarcoidosis, 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)

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

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)

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

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 (reslizumab), 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)

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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)

For Allergic Fungal Rhinosinusitis:

Does patient have documentation of an inflammatory response to fungal hyphae by evidence of sensitization to fungus by skin testing or positive fungal-specific IgE in serum? Yes No (Please provide documentation)

Does patient have confirmed nasal polyps? Yes No (Please provide documentation)

Does patient have evidence of at least one of the below? Yes No (Please provide documentation)

- Hyperdensities
- Bony demineralization
- Bone erosion of sinus

Does patient have sinus opacification on CT scan? Yes No (Please provide documentation)

If "Yes" to sinus opacification, does patient have an LMK score of 9 for patients with unilateral polyps or 12 for patients with bilateral polyps? Yes No (Please provide documentation)

Does patient have nasal cavity malignant or benign tumors? Yes No (Please provide documentation)

Does patient have known fungal invasion into the sinus tissue? Yes No (Please provide documentation)

Have all all other nasal conditions/diseases have been ruled out? Yes No (Please provide documentation)

Renewal for Allergic fungal rhinosinusitis:

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 (reslizumab), Fasenra (benralizumab)]
- Anti-interleukin 31 therapy[e.g. Nemluvio(nemolizumab-ilto)
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

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

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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:** _____

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MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
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