



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: [HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI DISCLOSURE AUTHORIZATION.PDF](https://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF)

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:
REQUESTOR (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):			

Continued on next page.





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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE): 	DURATION OF THERAPY (SPECIFY DATES): 	RESPONSE/REASON FOR FAILURE/ALLERGY:
2. LIST DIAGNOSES: <input type="checkbox"/> Moderate to severe atopic dermatitis <input type="checkbox"/> Moderate-to-severe persistent asthma <input type="checkbox"/> Chronic rhinosinusitis with nasal polyps <input type="checkbox"/> Eosinophilic Esophagitis <input type="checkbox"/> Prurigo nodularis <input type="checkbox"/> Other Diagnosis _____ ICD-10 Code(s): _____		ICD-10:
3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.		
<p>Will patient use in conjunction with a clinical trial?</p> <p>Is prescriber one of the following or in consultation with one of the following: ? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please provide documentation.</i></p> <input type="checkbox"/> Allergist <input type="checkbox"/> Immunologist <input type="checkbox"/> Dermatologist <input type="checkbox"/> Pulmonologist <input type="checkbox"/> Otolaryngologist <p>Will patient use Dupixent in combination with one of the following? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <input type="checkbox"/> Nucala(mepolizumab), Cinqair (reslizumab), Fasentra (benralizumab) <input type="checkbox"/> Xolair(omalizumab) <input type="checkbox"/> Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)] <p>Will Dupixent(dupilumab) be used in combination with Cibinqo(abrocitinib), Olumiant(baracitinib), RinvoqER(upadacitinib) ,Opzelura(ruxolitinib) or Adbry(tralokinumab)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		
<p>For diagnosis of Atopic Dermatitis, answer the following:</p> <p>Has the patient had the diagnosis of atopic dermatitis for at least 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Please submit documentation.</i></p> <p>Does the patient have atopic dermatitis on at least 10% or more of their body surface area? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Please submit documentation.</i></p> <p>Has the patient tried at least two different topical steroids? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Please submit documentation.</i></p>		





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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.*

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*

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*





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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.*

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.*

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.*

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.





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

CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program
Attn: CP - 4201
P.O. Box 64811
St. Paul, MN 55164-0811

