Dupixent (Dupilumab)
Prior Authorization Request Form

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

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

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:**
☐ **NEW THERAPY** ☐ **RENEWAL** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

Continued on next page.

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

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 ☐ Other Diagnosis_____ICD-10 Code(s):_____	

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

Prescriber's Specialty:

Is the prescriber a dermatologist or an allergist? ☐ **Yes** ☐ **No**

Will patient use Dupixent in combination with Nucala(mepolizumab) or Fasenra(benralizumab) or Xolair(omalizmab)? ☐ **Yes** ☐ **No**

For diagnosis 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.***

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.***

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

Does the patient have moderate to severe persistent asthma for at least one year? ☐ **Yes** ☐ **No**

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

Is the patient a current smoker? ☐ **Yes** ☐ **No**

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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 received systemic (oral or injectable) glucocorticoids in the past 2 months? □ Yes □ No

Has the patient received more than 3 courses of systemic (oral or injectable) glucocorticoids in the past 6 months? □ Yes □ No

Is the patient currently on a beta-blocker? □ 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

<u>For diagnosis of chronic rhinosinusitis with nasal polyps, answer the following:</u>

Does patient have at least a 2 month use of a nasal steroid? □ Yes □ No ***Please submit documentation.***

Has patient had nasal surgery in the last 6 months? □ Yes □ No

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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: Magellan Rx Management Prior Authorization Program; c/o Magellan Health, Inc.
4801 E. Washington Street, Phoenix, AZ 85034
Phone: 877-228-7909