



Request for Prior Authorization
Dupilumab (Dupixent)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization is required for Dupixent (dupilumab). Payment will be considered for patients when the following criteria are met:

- 1) Patient has a diagnosis of moderate-to-severe atopic dermatitis; and
2) Patient is within the FDA labeled age; and
3) Is prescribed by or in consultation with a dermatologist; and
4) Patient has failed to respond to good skin care and regular use of emollients; and
5) Patient has documentation of an adequate trial and therapy failure with one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; and
6) Patient has documentation of a previous trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and
7) Patient has documentation of a previous trial and therapy failure with cyclosporine or azathioprine; and
8) Patient will continue with skin care regimen and regular use of emollients; and
9) Dose does not exceed an initial one-time dose of 600mg and maintenance dose of 300mg thereafter given every other week.

If criteria for coverage are met, initial authorizations will be given for 16 weeks to assess the response to treatment. Requests for continuation of therapy will require documentation of a positive response to therapy. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Non-Preferred

[ ] Dupixent

Strength

Usage Instructions

Quantity

Day's Supply

Diagnosis: \_\_\_\_\_

Is prescriber a dermatologist?

[ ] Yes [ ] No If no, note consultation with dermatologist:

Consultation date: \_\_\_\_\_ Physician name & phone: \_\_\_\_\_

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**Did patient fail to respond to good skin care and regular use of emollients?**

Yes  No If yes, provide documentation below:

Provide skin care regimen, including name and dates of emollient use: \_\_\_\_\_

**Will patient continue skin care regimen and regular use of emollients?**  Yes  No

**Preferred medium to high potency topical corticosteroid trial:**

Drug name & dose: \_\_\_\_\_ Trial dates: \_\_\_\_\_

Failure reason: \_\_\_\_\_

**Topical immunomodulator trial:**

Drug name & dose: \_\_\_\_\_ Trial dates: \_\_\_\_\_

Failure reason: \_\_\_\_\_

**Cyclosporine or Azathioprine trial:**

Drug name & dose: \_\_\_\_\_ Trial dates: \_\_\_\_\_

Failure reason: \_\_\_\_\_

Medical or contraindication reason to override trial requirements: \_\_\_\_\_

**Renewal requests:**

Document positive response to therapy: \_\_\_\_\_

**Attach lab results and other documentation as necessary.**

Prescriber signature (Must match prescriber listed above.)	Date of submission
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**IMPORTANT NOTE:** In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.