



**Request for Prior Authorization
Dupilumab (Dupixent)**

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID # 	Patient name	DOB
Patient address		
Provider NPI 	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI 	Pharmacy fax	NDC

Prior authorization is required for Dupixent (dupilumab). Payment will be considered under the following conditions:

- 1) Patient is within the FDA labeled age for indication; and
- 2) Patient has a diagnosis of moderate-to-severe atopic dermatitis; and
 - a. Is prescribed by or in consultation with a dermatologist, allergist, or immunologist; and
 - b. Patient has failed to respond to good skin care and regular use of emollients; and
 - c. 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
 - d. Patient has documentation of a previous trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and
 - e. Patient has documentation of a previous trial and therapy failure with cyclosporine or azathioprine; and
 - f. Patient will continue with skin care regimen and regular use of emollients; or
- 3) Patient has a diagnosis of moderate to severe asthma with an eosinophilic phenotype (with a pretreatment eosinophil count ≥ 150 cells/mcL within the previous 6 weeks) OR with oral corticosteroid dependent asthma; and
 - a. Is prescribed by or in consultation with an allergist, immunologist, or pulmonologist; and
 - b. Has a pretreatment forced expiratory volume in 1 second (FEV₁) $\leq 80\%$ predicted; and
 - c. Symptoms are inadequately controlled with documentation of current treatment with a high-dose inhaled corticosteroid (ICS) given in combination with a controller medication (e.g. long acting beta₂ agonist [LABA], leukotriene receptor antagonist [LTRA], oral theophylline) for a minimum of 3 consecutive months. Patient must be compliant with therapy, based on pharmacy claims; and
 - d. Patient must have one of the following, in addition to the regular maintenance medications defined above:
 - i. Two (2) or more exacerbations in the previous year, or
 - ii. Require daily oral corticosteroids for at least 3 days; and
- 4) Dose does not exceed the FDA approved dosing for indication.

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.

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Non-Preferred

Dupixent

Strength

Usage Instructions

Quantity

Day's Supply

Diagnosis: _____

Moderate-to-Severe Atopic Dermatitis

Is prescriber a dermatologist, allergist, or immunologist?

Yes specialty: _____

No If no, note consultation with dermatologist, allergist, or immunologist:

Consultation date: _____ Physician name, specialty & phone: _____

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: _____

Moderate-to-Severe Asthma with an Eosinophilic Phenotype

Does patient have pretreatment eosinophil count \geq 150 cells/mcL within the previous 6 weeks?

Yes (attach results) No

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Does patient have oral corticosteroid dependent asthma?

Yes No

Is prescriber an allergist, immunologist, or pulmonologist?

Yes specialty: _____

No If no, note consultation with allergist, immunologist, or pulmonologist:

Consultation date: _____ Physician name, specialty & phone: _____

Does patient have a pretreatment FEV₁ ≤ 80% predicted?

Yes (attach results) No

Document current treatment with a high-dose ICS given in combination with a controller medication:

High-Dose ICS Trial:

Drug name & dose: _____ Trial dates: _____

Failure reason: _____

Controller Medication Trial:

Drug name & dose: _____ Trial dates: _____

Failure reason: _____

Does patient have one of the following?

Two (2) or more exacerbations in the previous year? Yes No

Require daily oral corticosteroids for at least 3 days? Yes No

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.