Iowa Medicaid
IOWA HHS

Request for Prior Authorization

Dupilumab (Dupixent)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

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 for non-preferred agents will be considered when there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered when patient has an FDA approved or compendia indication for the requested drug under the following conditions:

1) Request adheres to all FDA approved labeling for requested drug and indication including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
2) Patient's current weight in kilograms (kg) is provided; and
3) 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
4) 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 (FEV_1) ≤ 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 $beta_2$ 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; or
5) Patient has a diagnosis of inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP); and
   a. Documentation dupilumab will be used as an add-on maintenance treatment; and
   b. Documentation of an adequate trial and therapy failure with at least one preferred medication from each of the following categories:
      i. Nasal corticosteroid spray; and
      ii. Oral corticosteroid; or
6) Patient has a diagnosis of eosinophilic esophagitis (EoE); and
   a. Is prescribed by, or in consultation with, and allergist, gastroenterologist, or immunologist; and
   b. Patient has ≥ 15 intraepithelial eosinophils per high-power field (eos/hpf) as confirmed by endoscopic esophageal biopsy (attach results); and
   c. Patient has signs and symptoms of esophageal dysfunction (e.g., dysphagia, food impaction, food refusal, abdominal pain. heartburn regurgitation, chest pain and/or, odynophagia); and
   d. Documentation of previous trials and therapy failures with all of the following:

i. High dose proton pump inhibitor (PPI) for at least 8 weeks; and
ii. Swallowed topical corticosteroid (e.g., fluticasone propionate, oral budesonide suspension); and
iii. Dietary therapy; and

7) Dose does not exceed the FDA approved dosing for indication.

If criteria for coverage are met, initial authorizations will be given for 6 months 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: _____

Patient's current weight in kg: _____ Date obtained: _____

☐ **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: _____

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☐ **Moderate-to-Severe Asthma with an Eosinophilic Phenotype**

Does patient have pretreatment eosinophil count ≥ 150 cells/mcL within the previous 6 weeks?
☐ Yes (attach results) ☐ No
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 FEV_1 ≤ 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

☐ **Inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP)**

Will dupliumab be used as an add-on maintenance treatment?

☐ Yes (document concomitant maintenance treatment): Drug name & dose: _____

☐ No

Document adequate trial and therapy failure with at least one preferred medication from each of the following categories:

Nasal Corticosteroid Spray Trial:

Drug name & dose:_____ Trial dates:_____

Failure reason:_____

Oral Corticosteroid Trial:

Drug name & dose:_____ Trial dates:_____

Failure reason:_____

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☐ **Eosinophilic Esophagitis (EoE)**

Is prescriber an allergist, immunologist, or gastroenterologist?

☐ Yes specialty: _____

☐ No If no, note consultation with allergist, immunologist, or gastroenterologist:

Consultation date:_____Physician name, specialty & phone:_____

_____

Does patient have ≥ 15 intraepithelial eosinophils per high-power field (eos/hpf) confirmed by endoscopic esophageal biopsy?

☐ Yes (attach results) ☐ No

Does patient have signs and symptoms of esophageal dysfunction?

☐ Yes; provide signs and symptoms: _____

☐ No

Document previous trials and therapy failures with all of the following:

High Dose PPI :

Drug name & dose:_____ Trial dates:_____

Failure reason:_____

Swallowed topical corticosteroid:

Drug name & dose:_____ Trial dates:_____

Failure reason:_____

Dietary Therapy:

Dietary Plan:_____ Trial dates:_____

Failure reason:_____

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

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.*