

Request for Prior Authorization Dupilumab (Dupixent)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

- 7) Patient has a diagnosis of moderate to severe prurigo nodularis (PN); and
- a. Patient has experienced severe to very severe pruritis, as demonstrated by a current Worst Itch-Numeric Rating Scale (WI-NRS) ≥ 7 ; and
 - b. Patient has ≥ 20 nodular lesions (attach documentation); and
 - c. Documentation of a previous trial and therapy failure with a high or super high potency topical corticosteroid for at least 14 consecutive days; or
- 8) Patient has a diagnosis of chronic obstructive pulmonary disease (COPD) and an eosinophilic phenotype; and
- a. Patient has moderate to severe airflow limitation, measured within the past 12 months, as evidenced by both of the following:
 - i. FEV1/FVC ratio < 0.7 , and
 - ii. FEV1 % predicted between 30% to 79%; and
 - b. Patient has a minimum blood eosinophil count of 300 cells/mcL, measured within the past 12 months; and
 - c. Patient has documentation of maximal inhaled therapy for 3 or more months and an inadequate response to:
 - i. Triple therapy with all of the following treatments:
 - 1. Long-acting muscarinic antagonist/anticholinergic (LAMA); and
 - 2. Long-acting beta agonist (LABA); and
 - 3. Inhaled corticosteroid (ICS); or
 - ii. Double therapy with all of the following if ICS is contraindicated
 - 1. LABA; and
 - 2. LAMA; and
 - d. Patient has history of at least 2 moderate or 1 severe exacerbation(s) in the previous 12 months despite receiving maximal triple therapy or double therapy (defined above). Moderate exacerbation is defined as patient required treatment with systemic corticosteroids and/or antibiotics and severe exacerbation is defined as hospitalization or observation for over 24 hours in an emergency department or urgent care facility; and
 - e. Patient will continue to receive maintenance therapy (as documented above) concomitantly with dupilumab; and
- 9) Dose does not exceed the FDA approved dosing for indication.

If criteria for coverage are met, initial authorizations will be given for 6 months for all the above indications, except COPD, which will receive an initial authorization of 12 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.

Preferred

Dupixent

Strength

Usage Instructions

Quantity

Day's Supply

Diagnosis: _____

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

Moderate-to-Severe Atopic Dermatitis

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: _____

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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: _____

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

Does patient have oral corticosteroid dependent asthma?

Yes No

Provide pretreatment FEV₁ % predicted (attach results): _____

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?

One (1) 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 dupilumab 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: _____

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Oral Corticosteroid Trial:

Drug name & dose: _____ Trial dates: _____

Failure reason: _____

Eosinophilic Esophagitis (EoE)

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: _____

Moderate to Severe Prurigo Nodularis (PN)

Worst Itch-Numeric Rating Scale (WI-NRS) response: _____ **Date obtained:** _____

Does patient have ≥ 20 nodular lesions? Yes (provide documentation) No

Preferred high or super high potency topical corticosteroid trial:

Drug name & dose: _____ Trial dates: _____

Failure reason: _____

Chronic Obstructive Pulmonary Disease (COPD) and an eosinophilic phenotype:

Provide all of the following information:

FEV1/FVC ratio: _____ **Date obtained:** _____

FEV1 % predicted: _____ **Date obtained:** _____

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Blood eosinophil count: _____ **Date obtained:** _____

Trial information:

LABA Trial:

Name/dose: _____ Trial dates: _____

Failure reason/medical contraindication: _____

LAMA Trial:

Name/dose: _____ Trial dates: _____

Failure reason/medical contraindication: _____

ICS Trial:

Name/dose: _____ Trial dates: _____

Failure reason/medical contraindication: _____

Document exacerbations:

Moderate:

Date: _____ **Treatment needed:** _____

Date: _____ **Treatment needed:** _____

Severe:

Date: _____ **Place of care:** _____

Will patient continue to receive maintenance therapy concomitantly with dupilumab? 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 Health and Human Services, that the member continues to be eligible for Medicaid.