PRESCRIPTION DRUG
MEDICATION REQUEST FORM
FAX TO 1-866-240-8123

DUPIXENT PRIOR AUTHORIZATION FORM

PATIENT INFORMATION

Subscriber ID Number		Group Number	
Patient Name	Patient Telephone Number		Date of Birth
Patient Address	City	State	Zip Code

PRESCRIBER INFORMATION

Physician Name	Phone		Fax
Physician Address	City	State	Zip Code
Suite / Building	Physician Signature		Date

MEDICATION INFORMATION

Requested Drug Strength: ☐ 200mg/1.14mL ☐ 300mg/2mL

Number of pens/syringes **per Month**

Diagnosis:

CLINICAL CRITERIA

If Dupixent is being used to treat **atopic dermatitis**, please answer the following:

1. Dupixent is being prescribed by a:
   ☐ Dermatologist ☐ Allergist ☐ Immunologist ☐ Other: _____
2. Does the patient have atopic dermatitis with facial or anogenital involvement?
   ☐ Yes ☐ No
3. Has the patient experienced therapeutic failure, intolerance, or contraindication to any of the following? Please select **ALL** that apply:
   ☐ A topical corticosteroid (e.g. Betamethasone, Clobetasol, Triamcinolone, etc.)
   ☐ Topical Tacrolimus (Protopic)
   ☐ Topical Pimecrolimus (Elidel)
4. Does the patient require induction dosing of 4 pens/syringes for the first 4 weeks of therapy?
   ☐ Yes ☐ No
5. Is this a request for reauthorization?
   ☐ Yes ☐ No

   a. If **YES**, has the patient experienced positive clinical response?
   ☐ Yes ☐ No

If Dupixent is being used to treat **moderate-to-severe asthma**, please answer the following:

1. Please provide all of the following:
   a. Patient's pretreatment forced expiratory volume in one second (FEV_1): _____% predicted
   b. Patient's FEV1 reversibility after albuterol (salbutamol) administration: _____%
   c. Blood eosinophil count: _____cells/mcL
2. Is the patient currently taking daily or alternate-day oral corticosteroids?
   ☐ Yes ☐ No
3. Is the patient using a medium- or high-dose inhaled corticosteroid?
   ☐ Yes ☐ No
4. Is the patient using a long-acting beta agonist?
   ☐ Yes ☐ No
5. Does the patient require induction dosing of 4 pens/syringes for the first 4 weeks of therapy?
   ☐ Yes ☐ No
6. Is this a request for reauthorization?
   ☐ Yes ☐ No
   a. If **YES**, please select **ALL** that apply:
      ☐ Patient has demonstrated improvement or stability
      ☐ Patient has decreased rescue medication or oral corticosteroid use
      ☐ Patient had a decrease in frequency of severe asthma exacerbations
      ☐ Patient had an increase in pulmonary function from baseline (e.g. FEV1)
      ☐ Patient had a reduction in reported asthma-related symptoms (e.g. asthmatic symptoms upon awakening, coughing, fatigue, shortness of breath, sleep disturbance, or wheezing)

If Dupixent is being used to treat **chronic rhinosinusitis with nasal polyposis**, please answer the following:

1. Please provide:
   a. Patient's baseline bilateral nasal polyp score (**from 0 to 8**): _____
      The Nasal Polyp Score is used to characterize the patient's polyps (sum of the left and right nostril scores).
      0 = no polyps
      8 = severe disease with large polyps causing complete obstruction of the inferior nasal cavity
   b. Patient's baseline nasal congestion score (**from 0 to 3**): _____
      The Nasal Congestion Score is a tool used to measure changes in nasal congestion and obstruction.
      0 = no symptoms
      3 = severe symptoms
2. Has the patient experienced therapeutic failure, intolerance, or contraindication to the following:
   Please select **ALL** that apply:
   ☐ An intranasal corticosteroid
   ☐ A 14-day course of oral corticosteroids
3. Is this a request for reauthorization?
   ☐ Yes ☐ No
   a. If **YES**, please select **ALL** that apply:
      ☐ Patient is responding to therapy
      ☐ Patient has a decrease in their nasal polyp score
      ☐ Patient has a reduction in their nasal congestion/obstruction severity score

The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

INSTRUCTIONS FOR COMPLETING THIS FORM

1. Submit a separate form for each medication.
2. Complete **ALL** information on the form.
   NOTE: *The prescribing physician (PCP or Specialist) should, in most cases, complete the form.*
3. Please provide the physician address as it is required for physician notification.
4. Fax the **completed** form and all clinical documentation to **1-866-240-8123**
   Or mail the form to: **Clinical Services,**
   120 Fifth Avenue, MC PAPHM-043B, Pittsburgh, PA 15222