

**DUPIXENT (dupilumab) [non-preferred] PRIOR AUTHORIZATION FORM**

Prior authorization guidelines for **Dupixent** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at <https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx>.

<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:			Specialty:	
Contact's phone number:		NPI:	State license #:	
LTC facility contact/phone:			Street address:	
Beneficiary name:		Suite #:	City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:	

**CLINICAL INFORMATION**

<b>Product requested:</b> Dupixent	Strength/formulation:	Weight: _____ lbs / kg
Directions:		Quantity: _____ Refills: _____
Diagnosis ( <i>submit documentation</i> ):		Diagnosis code ( <i>required</i> ):
Is Dupixent being prescribed by or in consultation with a specialist?		<input type="checkbox"/> Yes <i>Submit documentation of consultation if applicable.</i> <input type="checkbox"/> No
Will the beneficiary be evaluated, monitored, and treated (if applicable) for helminth infection?		<input type="checkbox"/> Yes <input type="checkbox"/> No

**INITIAL requests**

Has the beneficiary taken Dupixent in the past 90 days?	<input type="checkbox"/> Yes – <i>Submit documentation.</i> <input type="checkbox"/> No
<input type="checkbox"/> <b>For the treatment of atopic dermatitis:</b> Which of the following treatments have been tried (or cannot be tried due to intolerance or contraindication) by the beneficiary? <i>Check all that apply. SUBMIT DOCUMENTATION for each.</i>	
<input type="checkbox"/> for the face or skin folds, low-potency (or higher) topical corticosteroids <input type="checkbox"/> a topical corticosteroid with a potency appropriate for the beneficiary's age and affected area(s) of the body <input type="checkbox"/> Elidel (pimecrolimus) or Protopic (tacrolimus) <input type="checkbox"/> phototherapy/photochemotherapy (e.g., PUVA, UVB light) <input type="checkbox"/> systemic immunosuppressives (e.g., acitretin, cyclosporine, methotrexate, mycophenolate)	
<input type="checkbox"/> <b>For the treatment of asthma:</b> Indicate which of the following apply to the beneficiary. <i>Check all that apply. SUBMIT DOCUMENTATION for each.</i>	
<input type="checkbox"/> has a diagnosis of asthma with an eosinophilic phenotype with an absolute blood eosinophil count $\geq$ 150 cells/microliter <input type="checkbox"/> has a diagnosis of oral corticosteroid-dependent asthma <input type="checkbox"/> has asthma that is moderate-to-severe <input type="checkbox"/> has tried or cannot use standard asthma controller medications (e.g., inhaled corticosteroids, inhaled long-acting beta agonists (LABAs), etc.) <input type="checkbox"/> has tried or cannot use the preferred MABs for asthma (Fasenra, Nucala, Xolair vial) <input type="checkbox"/> will use Dupixent in addition to tolerated standard asthma controller medications (e.g., inhaled corticosteroids, inhaled LABAs, etc.)	
<input type="checkbox"/> <b>For treatment of chronic rhinosinusitis with nasal polyposis:</b> Which of the following treatments have been tried (or cannot be tried due to intolerance or contraindication) by the beneficiary? <i>Check all that apply. SUBMIT DOCUMENTATION for each.</i>	
<input type="checkbox"/> A 14-day or longer course of systemic glucocorticoids <input type="checkbox"/> Sino-nasal surgery <input type="checkbox"/> Maintenance nebulized or irrigated intranasal glucocorticoids	
<input type="checkbox"/> <b>For a diagnosis other than the approved indication(s),</b> submit documentation of other treatments tried.	

**RENEWAL requests**

Since starting Dupixent, did the beneficiary experience a positive clinical response and/or improvement in disease severity?	<input type="checkbox"/> Yes <i>Submit documentation of clinical response.</i> <input type="checkbox"/> No
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**PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION**

<b>Prescriber Signature:</b>	<b>Date:</b>
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