

DUPIXENT (dupilumab) PRIOR AUTHORIZATION FORM *(form effective 1/9/2023)*

Prior authorization guidelines for **Dupilumab** 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:			City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:	

CLINICAL INFORMATION

Drug requested: Dupixent	Strength/formulation:	Weight: _____ lbs / kg	
Directions:		Quantity:	Refills:
Diagnosis (<i>submit documentation</i>):		Diagnosis code (<i>required</i>):	
Is Dupixent prescribed by or in consultation with a specialist (eg, allergist, dermatologist, hematologist/oncologist, immunologist, pulmonologist, rheumatologist, etc)?		<input type="checkbox"/> Yes <i>Submit documentation of</i> <input type="checkbox"/> No <i>consultation if applicable.</i>	

Complete the section(s) below applicable to the beneficiary and this request and **SUBMIT DOCUMENTATION** for each item.

INITIAL requests

- For the treatment of atopic dermatitis:** Which of the following treatments have been tried (or cannot be tried due to intolerance or contraindication) by the beneficiary? *Check all that apply.*
 - For the face, skin folds, or other critical areas, a 4-week trial of a low-potency (or higher) topical corticosteroid
 - For other body areas, a 4-week trial of a medium potency or higher topical corticosteroid
 - An 8-week trial of Elidel (pimecrolimus) or Protopic (tacrolimus)
 - Phototherapy / photochemotherapy (e.g., PUVA, UVB light)
 - Systemic immunosuppressives (e.g., azathioprine, cyclosporine, methotrexate, mycophenolate)
- For the treatment of asthma:** Indicate which of the following apply to the beneficiary. *Check all that apply.*
 - Has a diagnosis of asthma with an eosinophilic phenotype with an absolute blood eosinophil count ≥ 150 cells/microliter
 - Has a diagnosis of oral corticosteroid-dependent asthma
 - Has asthma that is moderate-to-severe
 - Has tried or cannot use standard asthma controller medications (e.g., inhaled corticosteroids, inhaled long-acting beta agonists [LABAs], etc.)
 - Will use Dupixent in addition to tolerated standard asthma controller medications (e.g., inhaled corticosteroids, inhaled LABAs, etc.)

3. For treatment of **chronic rhinosinusitis with nasal polyposis**:

Will use Dupixent as an add-on maintenance treatment for inadequately controlled chronic rhinosinusitis with nasal polyposis

4. For treatment of **eosinophilic esophagitis**:

Has tried and failed or cannot try (due to intolerance or contraindication) a proton pump inhibitor (eg, omeprazole, lansoprazole, etc)

5. **Other diagnosis**: _____

List other treatments tried (including start/stop dates, dose, outcomes, etc.): _____

RENEWAL requests

1. For the treatment of **asthma**:

Has documented measurable evidence of improvement in the beneficiary's asthma

Maintained asthma control while decreasing the oral corticosteroid dose

Continues to use Dupixent in addition to tolerated standard asthma controller medications (e.g., inhaled corticosteroids, inhaled LABAs, etc.)

2. For the treatment of **all other diagnoses**:

Has documented evidence of improvement in disease severity

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:

Date:

Confidentiality Notice: The documents accompanying this telecopy may contain confidential information belonging to the sender. The information is intended only for the use of the individual named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any telecopy is strictly prohibited.