

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

DUPIXENT PRIOR AUTHORIZATION FORM PATIENT INFORMATION							
Subscribe	er's ID Number				Subscriber's Group Number		
Patient's I	Name			Phone	Date of Birth		
Address			City	I State	Zip Code		
		PRESCI	RIBER	INFORMATION			
Physician	's Name	NPI		Phone	Fax		
Address			City	State	Zip Code		
Suite / Bu	ilding	Physician's Signature			Date		
		MEDICA	ATION	INFORMATION			
Reque	sted Strength:						
□ 100	mg/0.67ml Syringe	☐ 200mg/1.14ml S	Syringe	☐ 300mg/2m	l Syringe		
		☐ 200mg/1.14ml P	Pen	☐ 300mg/2m	l Pen		
Quant	ity:				Number of pens/syringes per		
Does t	he patient require induc		syringes	for the first 4 weeks of	month for maintenance dosing:		
		therapy? ☐ Yes ☐ No					
Diagno	osis:						
		CLI	NICAL	CRITERIA			
If Dupi	xent is being used to tre	eat moderate-to-severe	atopic	dermatitis, please and	swer the following:		
1.	Dupixent is being pres	scribed by a:					
	☐ Dermatologist	☐ Allergist		☐ Immunologist	☐ Other:		
2.							
	 ☐ A generic topical corticosteroid (e.g. Betamethasone, Clobetasol, Triamcinolone, etc.) ☐ Generic topical Tacrolimus ☐ Generic topical Pimecrolimus 						
3.							
4.							
5.	Is this a request for re ☐ Yes ☐ No	authorization?					
	a. If YES , has the pa	atient experienced posi No	itive clini	cal response to therap	y with Dupixent?		

If Dupix	kent is being used to treat moderate-to-severe <u>asthma</u> , please answer the following:
1.	Please provide ALL of the following:
	a. Patient's pretreatment FEV1:% predicted
2.	Does the patient have FEV1 reversibility of at least 12% and 200 milliliters (ml) after albuterol (salbutamol) administration? ☐ Yes ☐ No
3.	Does the patient have eosinophilic phenotype with blood eosinophil count greater than or equal to 150 cells/microliter? □ Yes □ No
4.	Is the patient currently taking daily or alternate-day oral corticosteroids? $\hfill \Box$ Yes $\hfill \Box$ No
5.	Is the patient using a medium- or high-dose inhaled corticosteroid? ☐ Yes ☐ No
6.	Is the patient using a long-acting beta agonist? ☐ Yes ☐ No
7.	Is this a request for reauthorization? ☐ Yes ☐ No
	 a. If YES, please select ALL that apply:
If Dupix	vent 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, the sum of right and left nostril scores, is used to characterize the patient's polyps. Each nostril is scored on a scale of 0 to 4, with the total score being the sum of left and right nostril scores. 0 = no polyps 4 = 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 has a decrease in the nasal polyp score Patient has a reduction in the nasal congestion/obstruction severity score

Dupixent is being used to treat eosinophilic esophagitis, please answer the following:							
1.	Does the patient weigh at least 40 kg? ☐ Yes ☐ No						
2.	Does the patient have an esophageal eosinophil count greater than or equal to 15 eos/hpf (eosinophils/high power field) on esophageal biopsy? \Box Yes \Box No						
3.	Does the patient have clinical symptoms of esophageal dysfunction (e.g., dysphagia, food impaction, gastroesophageal reflux)? \Box Yes \Box No						
4.	. Has the patient experienced two or more episodes of dysphagia per week? \Box Yes \Box No						
5.	. Has the patient experienced therapeutic failure, contraindication, or intolerance to high-dose proton-pump inhibitor (PPI) therapy (e.g. omeprazole or pantoprazole 80 mg/day)? ☐ Yes ☐ No						
6.	Is this a request for reauthor ☐ Yes ☐ No	ization?					
	a. If YES , please select AL	_L that apply:					
	☐ Patient experienced	histological remission	n (i.e. less than 15 eos/hpf) o	n esophageal biopsy			
	Patient experienced	· · · · · · · · · · · · · · · · · · ·					
	•	-	requency of clinical symptom	s of esophageal dysfunction (e.g.			
	food impaction, gastroes	sopriagear reliux)					
f Dupix	xent is being used to treat pru	<u>ırigo nodularis,</u> plea	ase answer the following:				
1.	Dupixent is being prescribed	d bv a:					
	2 ap	,					
	□ Dermatologist	☐ Allergist	☐ Immunologist	☐ Other:			
2.	□ DermatologistHas the patient experienced corticosteroid?□ Yes□ No	☐ Allergist I therapeutic failure, in	☐ Immunologist ntolerance, or contraindication	Other:			
2.	Has the patient experienced corticosteroid? ☐ Yes ☐ No	therapeutic failure, in	ntolerance, or contraindication				
	Has the patient experienced corticosteroid? Yes No Does the patient have prurigimpractical to apply?	therapeutic failure, ingo nodularis with a lar	ntolerance, or contraindication	on to one generic topical			
3.	Has the patient experienced corticosteroid? Yes No Does the patient have prurigimpractical to apply? Yes No Does the patient have pruriging No	I therapeutic failure, in go nodularis with a large nodularis with seven prization?	ntolerance, or contraindication rge BSA (body surface area) erely damaged skin?	on to one generic topical			
3. 4.	Has the patient experienced corticosteroid? Yes No Does the patient have prurigimpractical to apply? Yes No Does the patient have prurigimpractical to apply? Yes No Is this a request for reauthomy Yes No a. If YES, has the patient experienced.	I therapeutic failure, in go nodularis with a large nodularis with seven prization?	ntolerance, or contraindication rge BSA (body surface area) erely damaged skin?	on to one generic topical			
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INSTRUCTIONS FOR COMPLETING THIS FORM

- 1. Submit a separate form for each medication.
- 2. Complete <u>ALL</u> 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