HIGHMARK | HIGHMARK

Medication Prior Authorization Form
Fax to 1-866-240-8123

Dupixent

Member Information:

Subscriber's ID Number			Subscriber's Group Number
Member's Name		Phone	Date of Birth
Address	City	State	Zip Code

Provider Information:

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

Medication Information:

Please specify the medication being requested:

☐ Dupixent 200mg/1.14ml syringe ☐ Dupixent 300mg/2ml syringe

☐ Dupixent 200mg/1.14ml pen ☐ Dupixent 300mg/2ml pen

Diagnosis and/or ICD-10 codes(s):

Quantity

Induction Dosing

Does the member require induction dosing?	Yes	No

Maintenance Dosing

Number of **pens/syringes**:	Requested Day Supply: ☐ 28 days ☐ 84 days ☐ Other: _____

Directions:

Member Weight

Member's weight (kilograms):

Clinical Information:

Dupixent is being prescribed by a:

☐ Dermatologist ☐ Allergist ☐ Immunologist ☐ Other:_____

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

1. Has the member experienced therapeutic failure or intolerance to any of the following? Please select **ALL** that apply:
   ☐ a generic topical corticosteroid
   ☐ generic topical tacrolimus
   ☐ generic topical pimecrolimus

2. Is the member incapable of applying topical therapies due to the extent of BSA (body surface area) involvement?	Yes	No
3. Does the member have severe atopic dermatitis with severely damaged skin?	Yes	No

4. Is the member currently on therapy with Dupixent?

   ☐ Yes ☐ No

   If **YES**, has the member experienced positive clinical response to therapy with Dupixent?

   ☐ Yes ☐ No

If Dupixent is being used to treat **prurigo nodularis**, please answer the following:

1. Does the member have at least 10 identifiable nodular lesions?	Yes	No
2. Has the member experienced therapeutic failure, intolerance, or contraindication to one generic topical corticosteroid?	Yes	No
3. Is the member incapable of applying topical therapies due to the extent of BSA (body surface area) involvement?	Yes	No
4. Does the member have severely damaged skin?	Yes	No

5. Is the member currently on therapy with Dupixent?
   ☐ Yes ☐ No

   If **YES**, please select **ALL** that apply:

   ☐ Member experienced a reduction in itch from baseline

   ☐ Member experienced a reduction in the number of nodules or lesions from baseline

If Dupixent is being used to treat **bullous pemphigoid**, please answer the following:

1. Has the member experienced therapeutic failure, contraindication, or intolerance to oral corticosteroids?	Yes	No
2. Has the member experienced therapeutic failure, contraindication, or intolerance to high potency to super high potency topical corticosteroids?	Yes	No

3. Is the member currently on therapy with Dupixent?
☐ Yes ☐ No

If **YES**, please select **ALL** that apply:

☐ Member experienced disease control (for example, no new lesions and existing lesions are beginning to heal)

☐ Member experienced a reduction in the number of relapses

☐ Member experienced improvement in bullous pemphigoid symptoms

☐ Member experienced a reduction in oral corticosteroid use

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

1. Please provide:

a. Member'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.

b. Member'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 member experienced therapeutic failure, intolerance, or contraindication to an intranasal corticosteroid?	Yes	No
3. Has the member experienced therapeutic failure, intolerance, or contraindication to a 14-day course of oral corticosteroids?	Yes	No

4. Is the member currently on therapy with Dupixent?

☐ Yes ☐ No

If **YES**, please select **ALL** that apply:

☐ Member had a decrease in the nasal polyp score

☐ Member had a reduction in the nasal congestion/obstruction severity score

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

1. Please provide the member's blood eosinophil count: _____ cells per microliter		
2. Does the member have a history of at least 2 asthma exacerbations requiring oral or injectable corticosteroid treatment in the previous 12 months (or within 12 months of starting Dupixent if the member is already on therapy)?	Yes	No
3. Does the member have a history of at least 1 asthma exacerbation requiring hospitalization in the previous 12 months (or within 12 months of starting Dupixent if the member is already on therapy)?	Yes	No
4. Is the member currently taking daily or alternate-day oral corticosteroids?	Yes	No
5. Does the member have inadequate symptom control despite regular treatment with medium- or high-dose inhaled corticosteroids and at least 1 additional asthma controller (for example, long-acting beta-2 agonist, leukotriene receptor antagonist, or theophylline)?	Yes	No
6. Will the member continue treatment with medium- or high-dose inhaled corticosteroids and at least 1 additional asthma controller (for example, long-acting beta-2 agonist, leukotriene receptor antagonist, or theophylline) while using Dupixent?	Yes	No
7. Is the member currently on therapy with Dupixent? ☐ Yes ☐ No If **YES**, please select **ALL** that apply: ☐ Member has decreased rescue medication or oral corticosteroid use ☐ Member had a decrease in frequency of severe asthma exacerbations ☐ Member had an increase in pulmonary function from baseline (for example, FEV1) ☐ Member had a reduction in reported asthma-related symptoms (for example, asthmatic symptoms upon awakening, coughing, fatigue, shortness of breath, sleep disturbance, or wheezing)		

If Dupixent is being used to treat **chronic obstructive pulmonary disease (COPD),** please answer the following:

1. Please provide:
   a. Member's post-bronchodilator FEV1: _____ % predicted
   b. Member's blood eosinophil count: _____ cells per microliter
   c. Member's modified Medical Research Council dyspnea scale score: _____
   The mMRC dyspnea scale is used to assess the degree of baseline functional disability due to dyspnea.

2. Is the member currently taking daily or alternate-day oral corticosteroids?	Yes	No
3. Has the member had at least 2 moderate exacerbations resulting in treatment with systemic corticosteroids and/or antibiotics in the previous year (or within a year of starting Dupixent if the member is already on therapy)?	Yes	No
4. Has the member had at least 1 severe exacerbation resulting in hospitalization or observation in the emergency department for over 24 hours in the previous year (or within a year of starting Dupixent if the member is already on therapy)?	Yes	No
5. Is the member's COPD classified as GOLD group E?	Yes	No
6. Does the member have inadequate symptom control despite regular treatment for at least 3 months with triple therapy consisting of a long-acting muscarinic antagonist, long-acting beta agonist, and inhaled corticosteroid, or does the member have intolerance or contraindication to all of these agents?	Yes	No

7. Is the member currently on therapy with Dupixent?

   ☐ Yes ☐ No

   If **YES**, please select **ALL** that apply:

   ☐ Member had a reduction in symptoms of COPD

   ☐ Member had an improvement in exercise tolerance

   ☐ Member had delayed disease progression

   ☐ Member had a reduction in the number of exacerbations

If Dupixent is being used to treat **chronic spontaneous urticaria (CSU)**, please answer the following:

1. Has the member been experiencing symptoms of CSU (hives and/or angioedema) for at least 6 weeks?	Yes	No
2. Has the prescriber ruled out other potential causes of urticaria (for example, chronic inducible urticaria, urticarial vasculitis, hereditary angioedema)?	Yes	No
3. Please indicate if the member has experienced therapeutic failure, contraindication, or intolerance to one of the following: ☐ Two second-generation non-sedating H1 antihistamines (for example: cetirizine, desloratadine, levocetirizine) at up to fourfold the maximum FDA recommended doses. ☐ One second-generation, non-sedating H1 antihistamine (for example: cetirizine, desloratadine, levocetirizine) at the maximum recommended dose. ☐ None of the above apply.		
4. Will the member use Dupixent in combination with Xolair and/or Rhapsido?	Yes	No
5. Is the member currently on therapy with Dupixent? ☐ Yes ☐ No If **YES**, please select **ALL** that apply: The member experienced improvement in CSU symptoms, as evidence by a reduction in: ☐ itch severity ☐ number or severity of hives ☐ number or severity of swelling episodes		

If Dupixent is being used to treat **allergic fungal rhinosinusitis**, please answer the following:

1. Was the member's diagnosis of allergic fungal rhinosinusitis confirmed by:		
a. type 1 hypersensitivity to fungus confirmed by history, in vitro IgE immunoassays, or skin testing?	Yes	No
b. positive fungal stain of sinus contents removed during surgery?	Yes	No
c. the presence of eosinophilic mucin without invasion into the sinus tissue?	Yes	No
d. the presence of Chronic Rhinosinusitis (CRS) with nasal polyposis (NP)?	Yes	No
e. characteristic CT signs (for example, heterogenous opacification, hyperdense areas, bony demineralization, bone erosion of sinus)?	Yes	No
2. Does the member have a history of sino-nasal surgery?	Yes	No

3. Is the member currently on therapy with Dupixent?
☐ Yes ☐ No

If **YES**, please select **ALL** that apply:

☐ Member had a decrease in their nasal polyp score
☐ Member had a reduction in their nasal congestion/obstruction severity score

If Dupixent is being used to treat **eosinophilic esophagitis**, please answer the following:

1. Does the member have an esophageal eosinophil count greater than or equal to 15 eos/hpf (eosinophils/high power field) on esophageal biopsy?	Yes	No
2. Does the member have clinical symptoms of esophageal dysfunction (for example, dysphagia, food impaction, gastroesophageal reflux)?	Yes	No
3. Does the member have a history of eosinophilic esophagitis signs or symptoms?	Yes	No
4. Has the member experienced two or more episodes of dysphagia per week?	Yes	No
5. Has the member experienced therapeutic failure, contraindication, or intolerance to high-dose proton-pump inhibitor (PPI) therapy (for example, omeprazole or pantoprazole 80 mg/day)?	Yes	No

6. Is the member currently on therapy with Dupixent?

☐ Yes ☐ No

If **YES**, please select **ALL** that apply:
☐ Member experienced histological remission (specifically, less than 15 eos/hpf) on esophageal biopsy
☐ Member experienced reduced severity or frequency of clinical symptoms of esophageal dysfunction (for example, dysphagia, food impaction, gastroesophageal reflux)

Medication History:

Please provide any other medications that the member has tried and failed:

_____

_____

_____

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 member. 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. Please print, type or write legibly in blue or black ink.
3. Complete **ALL** information on the form.
   NOTE: *The prescribing physician (PCP or Specialist) should, in most cases, complete the form.*
4. Please provide the physician address as it is required for physician notification.
5. Fax the **completed** form and all clinical documentation to **1-866-240-8123**
   Or mail the form to: **120 Fifth Avenue, SPECARE, Pittsburgh, PA 15222**

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