OKLAHOMA Health Care Authority

State of Oklahoma SoonerCare
Dupixent® (Dupilumab) Prior Authorization Form

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Member Name:_____ **Date of Birth:**_____ **Member ID#:**_____

Drug Information

Pharmacy billing (NDC:_____) Fill Date:_____

Dose:_____ Regimen:_____

Billing Provider Information

Pharmacy NPI:_____ Pharmacy Name:_____

Pharmacy Phone:_____ Pharmacy Fax:_____

Prescriber Information

Prescriber NPI:_____ Prescriber Name:_____

Prescriber Phone:_____ Prescriber Fax:_____ Specialty:_____

Clinical Information

For Initial Authorization:

1. Please indicate diagnosis:
   - ❑ Moderate-to-Severe Eosinophilic Phenotype Asthma
   - ❑ Oral Corticosteroid-Dependent Asthma
   - ❑ Moderate-to-Severe Atopic Dermatitis
   - ❑ Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP)
   - ❑ Eosinophilic Esophagitis (EoE)
   - ❑ Prurigo Nodularis (PN)
   - ❑ Other, please list: _____

   A. Has the member been counseled on proper administration and storage of Dupixent®? Yes☐ No☐
   B. Has the member been evaluated by an allergist, gastroenterologist, dermatologist, immunologist, otolaryngologist, pulmonologist, pulmonary specialist within the last 12 months (or an advanced care practitioner with a supervising physician who is one of these specialties)? Yes☐ No☐
      i. If yes, please include name of specialist: _____ Specialty:_____
   C. Will the member be using Dupixent® concurrently with other biologic medications? Yes☐ No☐
      i. If yes, please provide patient-specific information to support the concurrent use of both medications:_____
   D. What is the member's weight? _____

2. If diagnosis is **Moderate-to-Severe Eosinophilic Phenotype Asthma or Oral Corticosteroid-Dependent Asthma**, please provide the following *(Initial approvals will be for the duration of 6 months):*

   A. Will this medication be used as add-on maintenance treatment? Yes☐ No☐
      i. If yes, please indicate member's daily medications and dose prescribed for treatment of this diagnosis:
      Drug/Dose:_____ Drug/Dose:_____
   B. Baseline blood eosinophil count: _____ Date Determined: _____
   C. Does member require daily systemic corticosteroids despite compliant use of high-dose inhaled corticosteroid (ICS) plus at least one additional controller medication? Yes☐ No☐
      i. If no, please list number and dates of exacerbations requiring systemic corticosteroids within last 12 months: Number: _____ Dates of exacerbations: _____
   D. Please check all that apply:
      - ❑ Member has failed a high-dose ICS (≥ 880 mcg/day fluticasone propionate or equivalent daily dose or ≥ 440 mcg/day in ages 12 to 17) used compliantly for at least the past 12 months (for ICS/LABA combination products, the highest approved dose meets this criteria)
        - Drug/Dose: _____
      - ❑ Member has failed at least 1 other asthma controller medication used in addition to the high-dose ICS compliantly for at least the past 3 months
        - Drug/Dose: _____

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization throughCoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma

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3. If diagnosis is **Moderate-to-Severe Atopic Dermatitis**, please provide the following *(Initial approvals will be for the duration of 16 weeks)*:
   A. Is member inadequately controlled with topical prescription therapies? Yes☐ No☐
   B. Has the member failed 1 medium potency to very-high potency Tier-1 topical corticosteroid? Yes☐ No☐
      i. If yes, please provide the medication and duration of treatment:
         a. Drug:_____ Date of trial:_____
         b. Was the trial at least 2 weeks in duration? Yes☐ No☐
      ii. If no, is there a contraindication or documented intolerance to medium potency to very-high potency Tier-1 topical corticosteroids? Yes☐ No☐
         a. If yes, please describe:_____
   C. Has the member failed 1 topical calcineurin inhibitor [e.g., Elidel® (pimecrolimus), Protopic® (tacrolimus)]? Yes☐ No☐
      i. If yes, please provide the medication and duration of treatment:
         a. Drug:_____ Date of trial:_____
         b. Was the trial at least 2 weeks in duration? Yes☐ No☐
      ii. If no, is there a contraindication or documented intolerance to topical calcineurin inhibitors? Yes☐ No☐
         a. If yes, please describe:_____

4. If diagnosis is **Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP)**, please provide the following (*Initial approvals will be for the duration of 6 months)*:
   A. Will Dupixent® be used as add-on maintenance treatment for inadequately controlled CRSwNP? Yes☐ No☐
   B. Does the member have a trial with intranasal corticosteroid that resulted in failure (or have a contraindication or documented intolerance)? Yes☐ No☐
      i. If yes, please provide the medication used and dates of use:_____
   C. Has the member required prior sino-nasal surgery? Yes☐ No☐
   D. Has the member been treated with systemic corticosteroids for CRSwNP in the past 2 years (or have a contraindication or documented intolerance)? Yes☐ No☐
   E. Does the member have symptoms of chronic rhinosinusitis (e.g., facial pain/pressure, reduction or loss of smell, nasal blockade/obstruction/congestion, nasal discharge) for 12 weeks or longer despite attempts at medical management ? Yes☐ No☐
   F. Does the member have evidence of nasal polyposis by direct examination, sinus CT scan, or endoscopy? Yes☐ No☐
   G. Will the member continue to receive intranasal corticosteroid therapy? Yes☐ No☐
      i. If no, does the member have a contraindication to intranasal corticosteroid therapy? Yes☐ No☐
         1. If yes, please provide the member's contraindication:_____

5. If diagnosis is **Eosinophilic Esophagitis (EoE)**, please provide the following *(Initial approvals will be for the duration of 6 months)*:
   A. Does the member have 2 or more episodes of dysphagia per week? Yes☐ No☐
   B. Does the member have ≥ 15 intraepithelial eosinophils per high-power field (eol/hpf)? Yes☐ No☐

(continued on next page)

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C. Has the member failed 1 high-dose proton pump inhibitor?
Yes☐ No☐
   i. If yes, please provide the medication and duration of treatment:
      a. Drug:_____ Date of trial:_____
      b. Was the trial at least 8 weeks in duration? Yes☐ No☐
   ii. If no, is there a contraindication or documented intolerance to high-dose proton pump inhibitors? Yes☐ No☐
      a. If yes, please describe:_____

D. Has the member failed 1 swallowed inhaled respiratory corticosteroid (e.g. budesonide)?
Yes☐ No☐
   i. If yes, please provide the medication and duration of treatment:
      a. Drug:_____ Date of trial:_____
      b. Was the trial at least 8 weeks in duration? Yes☐ No☐
   ii. If no, is there a contraindication or documented intolerance to swallowed inhaled respiratory corticosteroids? Yes☐ No☐
      a. If yes, please describe:_____

6. If diagnosis is **Prurigo Nodularis (PN)**, please provide the following (*Initial approvals will be for the duration of 6 months)*:
   A. Has the member had a diagnosis of PN for at least 3 months? Yes☐ No☐
   B. Does the member have a Worst-Itch Numeric Rating Scale (WI-NRS) score of ≥ 7? Yes☐ No☐
   C. Does the member have ≥ 20 PN lesions? Yes☐ No☐
   D. Has the prescriber ruled out all other causes of pruritis? Yes☐ No☐
   E. Has the member failed 1 medium potency to very-high potency Tier-1 topical corticosteroid?
   Yes☐ No☐
      i. If yes, please provide the medication and duration of treatment:
         a. Drug:_____ Date of trial:_____
         b. Was the trial at least 2 weeks in duration? Yes☐ No☐
      ii. If no, is there a contraindication or documented intolerance to medium potency to very-high potency Tier-1 topical corticosteroids? Yes☐ No☐
         a. If yes, please describe:_____
   F. Has the member failed 1 topical calcineurin inhibitor [e.g., Elidel® (pimecrolimus), Protopic® (tacrolimus)]?
   Yes☐ No☐
      i. If yes, please provide the medication and duration of treatment:
         a. Drug:_____ Date of trial:_____
         b. Was the trial at least 2 weeks in duration? Yes☐ No☐
      ii. If no, is there a contraindication or documented intolerance to topical calcineurin inhibitors? Yes☐ No☐
         a. If yes, please describe:_____

For Continued Authorization:
1. Is member compliant with therapy? Yes☐ No☐
2. Is member responding well to therapy? Yes☐ No☐

Compliance with all of the prior authorization criteria is a condition for payment for this drug by SoonerCare. All information must be provided and SoonerCare may verify through further requested documentation. The member's drug history will be reviewed prior to approval.

Prescriber Signature:_____ **Date:**_____
By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.
Please do not send in chart notes. Specific information/documentation will be requested if necessary.
Please complete and return all pages. *Failure to complete all pages will result in processing delays.*
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