Mountain-Pacific Quality Health
Partnering within our communities to provide solutions for better health
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Montana Healthcare Programs Prior Authorization Request Form for Use of Dupixent® (dupilumab)

Member Name:	DOB:	Date:
Member ID:	Prescriber Phone:	
Prescriber Name/Specialty if applicable:	Prescriber Fax:	
Dosage Requested:		

Please complete below information for applicable situation, Initiation or Continuation of therapy:

☐ **INITIATION OF THERAPY**

Please check appropriate diagnosis and complete corresponding information:

1. **Atopic Dermatitis**:
   a. Member is 6 months of age or older: ☐ Yes ☐ No
   b. Member has a diagnosis of moderate to severe atopic dermatitis: ☐ Yes ☐ No
   c. Current weight of member: _____
   d. Medication is prescribed by, or in consultation with: ☐ Dermatologist ☐ Allergist
      - ***Action Required***: If not written by a specialist, a copy of the annual specialty consult is required (please attach copy of consult):

      Name of Specialist: _____ **Contact Date**: _____
   e. Member has clinical documentation of functional impairment due to atopic dermatitis, which may include, but is not limited to, limitations to activities of daily living (ADLs), such as skin infections or sleep disturbances and a baseline assessment has been made to allow for documentation of positive clinical response: ☐ Yes ☐ No
   f. Member must have had an inadequate treatment response, intolerance, or contraindication to all of the following (in listed order):
      - A preferred moderate to very high-potency topical corticosteroid: ☐ Yes ☐ No
        Drug Name: _____ **Dates of Use**: _____
      - If ≥2 years of age, a topical immunomodulator (pimecrolimus or tacrolimus): ☐ Yes ☐ No
        ☐ N/A due to age **Drug Name**: _____ **Dates of Use**: _____

      NOTE: Inadequate treatment response to topical therapy is defined as failure to achieve and maintain remission or a low disease activity state despite treatment with a daily regimen, applied for ≥ 28 days or for the maximum duration recommended by the product prescribing information (e.g., 14 days for high or very-high potency topical corticosteroids)
   g. Provider attests that member **will not** use Dupixent® concomitantly with other biologics: ☐ Yes ☐ No

2. **Moderate to Severe Asthma with Eosinophilic Phenotype**

a. Member is 6 years of age or older: ☐ Yes ☐ No
b. Medication is prescribed by, or in consultation with: ☐Allergist ☐ Pulmonologist ☐Immunologist
   - ***Action Required***: If not written by a specialist, a copy of the annual specialty consult is required (please attach copy of consult):

     Name of Specialist: _____ **Contact Date**: _____
c. Member has a history of moderate to severe asthma attacks despite treatment with the following medications at optimized doses in combination for 3 consecutive months:
   - An inhaled corticosteroid (ICS): ☐ Yes ☐ No
     Drug Name:_____ **Dates of Use**:_____
   - A long-acting beta2-agonist (LABA): ☐ Yes ☐ No
     Drug Name:_____ **Dates of Use**:_____
d. Provide initial baseline peripheral blood eosinophil count (attach lab):

   Date:_____ **Results**:_____ cells/microliter (criteria: ≥ 300 cells/microliter within last yr or ≥ 150 cells/microliter within last 6 weeks)
e. Provider attests that member **will not** use Dupixent® concomitantly with other biologics: ☐ Yes ☐ No

3. **Corticosteroid Dependent Asthma**
   a. Member is 6 years of age or older: ☐ Yes ☐ No
   b. Medication is prescribed by, or in consultation with: ☐Allergist ☐ Pulmonologist ☐Immunologist
      - ***Action Required***: If not written by a specialist, a copy of the annual specialty consult is required (please attach copy of consult):

        Name of Specialist: _____ **Contact Date**: _____
   c. Member has a history of moderate to severe asthma attacks despite treatment with the following medications at optimized doses in combination for 3 consecutive months:
      - An inhaled corticosteroid (ICS): ☐ Yes ☐ No
        Drug Name:_____ **Dates of Use**:_____
      - A long-acting beta2-agonist (LABA): ☐ Yes ☐ No
        Drug Name:_____ **Dates of Use**:_____
      - An oral corticosteroid (OCS): ☐ Yes ☐ No
        Drug Name:_____ **Dates of Use**:_____
   d. Provider attests that member **will not** use Dupixent® concomitantly with other biologics: ☐ Yes ☐ No

4. **Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP):**
   a. Member is 18 years of age or older: ☐ Yes ☐ No
   b. Medication is prescribed by, or in consultation with: ☐ Allergist ☐ Immunologist ☐ Otolaryngologist
      - ***Action Required***: If not written by a specialist, a copy of the annual specialty consult is required (please attach copy of consult):

        Name of Specialist: _____ Contact Date: _____
   c. Member has clinical documentation of chronic rhinosinusitis WITH nasal polyps as evidenced by CT scan or endoscopy: ☐ Yes ☐ No
   d. Member must have had an inadequate treatment response, intolerance, or contraindication to both of the following:
      - **One** different intranasal corticosteroids*: ☐ Yes ☐ No
        ***Note**: Must have been adherent to therapy at optimized doses for at least 3 months*

Drug Name: _____ **Dates of Use**:_____

- Systemic corticosteroid trial (must be within last year): ☐ Yes ☐ No

  Drug Name:_____ **Dates of Use**:_____

  *and/*or

  sino-nasal surgery: ☐ Yes ☐ No **Surgery Date(s)**: _____

e. Member will concomitantly use an intranasal corticosteroid: ☐ Yes ☐ No - contraindicated in member

f. Provider attests that member **will not** use Dupixent® concomitantly with other biologics: ☐ Yes ☐ No

5. **Eosinophilic Esophagitis (EoE)**
   a. Member is 12 years of age or older AND weighs at least 40kg: ☐ Yes ☐ No Current Weight: _____
   b. Medication is prescribed by, or in consultation with: ☐ Allergist ☐ Gastroenterologist
      - ***Action Required***: If not written by a specialist, a copy of the annual specialty consult is required (please attach copy of consult):

        Name of Specialist: _____ **Contact Date:** _____
   c. Member has a diagnosis of eosinophilic esophagitis with documentation of ≥15 intraepithelial eosinophils per high-power field (eos/hpf) AND symptoms of dysphagia as measured by the Dysphagia Symptom Questionnaire (DSQ): ☐ Yes ☐ No

      Please provide eos/hpf results: _____ **Date**: _____
   d. In the past 6 months, member has had an inadequate treatment response, intolerance, or contraindication to a swallowed topical corticosteroid (i.e., budesonide, fluticasone, etc.) for a minimum trial period of at least 4 weeks: ☐ Yes ☐ No

      Drug Name: _____ **Dates of Use**: _____
   e. Provider attests that member **will not** use Dupixent® concomitantly with other biologics: ☐ Yes ☐ No

6. **Prurigo Nodularis**
   a. Member is 18 years of age or older: ☐ Yes ☐ No
   b. Member has a confirmed diagnosis, by microscopic examination of lesion or biopsy, of prurigo nodularis (please attach copy of lab): ☐ Yes ☐ No
   c. Medication is prescribed by, or in consult with a Dermatologist: ☐ Yes ☐ No
      - ***Action Required***: If not written by a specialist, a copy of the annual specialty consult is required (please attach copy of consult):

        Name of Specialist: _____ **Contact Date**: _____
   d. Member has a Worst Itch Numerical Rating Scale (WI-NRS) of ≥7 points (0-10 scale): ☐ Yes ☐ No

      Worst Itch Numerical Rating: _____
   e. Member has 20 or more nodular lesions: ☐ Yes ☐ No

      Number of nodular lesions: _____
   f. Provider attests that member **will not** use Dupixent® concomitantly with other biologics: ☐ Yes ☐ No

LIMITATIONS:

- Atopic Dermatitis: Max initial authorization: 2 x 300 mg syringes (loading dose) and 1 x 300 mg syringe every other week for maintenance therapy
- Asthma: Max 2 x 200 mg syringes (loading dose) and 1 x 200 mg every other week for maintenance or 2 x 300 mg (loading dose) and 1 x 300 mg every other week for maintenance therapy
- CRSwNP: Max 2 x 300 mg syringes every month

- EoE: Max dose is 300mg weekly
- Prurigo Nodularis: Max initial authorization: 2 x 300 mg syringes (loading dose) and 1 x 300 mg syringe every other week for maintenance therapy

Initial authorization will be issued for 6 months

☐ **CONTINUATION OF THERAPY**

1. **Atopic dermatitis*:***
   a. Member has documentation of positive clinical response to Dupixent® therapy (e.g., reduction in body surface area involvement, reduction in pruritus severity or decrease in severity index using a scoring tool): ☐ Yes ☐ No
   b. Annual specialist consult attached if prescriber is not a specialist: ☐ Yes ☐ No ☐ N/A prescriber is specialist
   c. Provider attests that member **will not** use Dupixent® concomitantly with other biologics: ☐ Yes ☐ No

2. **Asthma (applies to both eosinophilic phenotype and corticosteroid dependent):**
   a. Member has been adherent to therapy: ☐ Yes ☐ No (will be verified through claims history)
   b. Documentation is attached supporting positive response to therapy as demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations, or medication dose reduction: ☐ Yes ☐ No
   c. Annual specialist consult attached if prescriber is not a specialist: ☐ Yes ☐ No ☐ N/A prescriber is specialist
   d. Provider attests that member **will not** use Dupixent® concomitantly with other biologics: ☐ Yes ☐ No

3. **CRSwNP:**
   a. Member has been adherent to therapy and concurrent intranasal corticosteroid (unless contraindicated): ☐ Yes ☐ No (will be verified through claims history)
   b. Documentation is attached supporting positive response to therapy as demonstrated by a reduction in severity of sino-nasal symptoms or systemic steroid reduction (if using): ☐ Yes ☐ No
   c. Annual specialist consult attached if prescriber is not a specialist: ☐ Yes ☐ No ☐ N/A prescriber is specialist
   d. Provider attests that member **will not** use Dupixent® concomitantly with other biologics: ☐ Yes ☐ No

4. **EOE**:
   a. Member has been adherent to therapy: ☐ Yes ☐ No (will be verified through claims history)
   b. Documentation is attached supporting positive clinical response to therapy by reduction in peak esophageal intraepithelial eosinophil count (<6 = remission): ☐ Yes ☐ No
   c. Member has documentation of positive clinical response to therapy by reduction in DSQ score (Dysphagia Symptom Questionnaire): ☐ Yes ☐ No
   d. Annual specialist consult attached if prescriber is not a specialist: ☐ Yes ☐ No ☐ N/A prescriber is specialist
   e. Provider attests that member **will not** use Dupixent® concomitantly with other biologics: ☐ Yes ☐ No

5. **Prurigo Nodularis**
   a. Member has been adherent to therapy: ☐ Yes ☐ No (will be verified through claims history)
   b. Member has documentation of positive clinical response to therapy by:
      ☐ Reduction in number and severity of nodules: **Number of nodular lesions**: _____
      OR
      ☐ Reduction from baseline WI-NRS score by ≥4 points: If yes, please provide current WI-NRS Score: _____
   c. Annual specialist consult attached if prescriber is not a specialist: ☐ Yes ☐ No ☐ N/A prescriber is specialist
   d. Provider attests that member **will not** use Dupixent® concomitantly with other biologics: ☐ Yes ☐ No

Reauthorization will be issued for 1 year

Please complete form, including required attachments and fax to:
11/2022 Drug Prior Authorization Unit @ 1-800-294-1350