Mountain Pacific
INNOVATING 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:	

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

☐ INITIATION OF THERAPY

Please check appropriate diagnosis and complete corresponding information:

☐ Atopic Dermatitis

1. Member is 6 months of age or older: ☐ Yes ☐ No
2. Member has a diagnosis of moderate to severe atopic dermatitis: ☐ Yes ☐ No
3. Current weight of member: _____
4. 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:** _____
5. 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
6. Member must have had an inadequate treatment response, intolerance or contraindication to **all** 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).
7. Provider attests member **will not** use Dupixent® concomitantly with other biologics: ☐ Yes ☐ No

☐ **Moderate to Severe Asthma with Eosinophilic Phenotype**

1. Member is 1 years of age or older AND weighs at least 15kg: ☐ Yes ☐ No Weight: _____
2. 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:** _____
3. 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**: _____
4. Provide initial baseline peripheral blood eosinophil count (attach lab):

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

☐ **Corticosteroid Dependent Asthma**

1. Member is 6 years of age or older: ☐ Yes ☐ No
2. 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:** _____
3. 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**: _____
4. Provider attests member **will not** use Dupixent® concomitantly with other biologics: ☐ Yes ☐ No

☐ **Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP):**

1. Member is 18 years of age or older: ☐ Yes ☐ No

2. Medication is prescribed by or in consultation with: ☐ Allergist ☐ Pulmonologist ☐ 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:** _____

3. Member has clinical documentation of chronic rhinosinusitis WITH nasal polyps as evidenced by CT scan or endoscopy: ☐ Yes ☐ No

4. Member must have had an inadequate treatment response, intolerance, or contraindication to **both** of the following:

   - **One** different intranasal corticosteroid*: ☐ 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)**: _____

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

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

☐ Eosinophilic Esophagitis (EoE)

1. Member is 12 years of age or older AND weighs at least 40kg: ☐ Yes ☐ No Current weight: _____

2. 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:** _____

3. 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:** _____

4. 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**: _____

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

☐ Prurigo Nodularis

1. Member is 18 years of age or older: ☐ Yes ☐ No

2. Member has a confirmed diagnosis, by microscopic examination of lesion or biopsy, of prurigo nodularis (please attach copy of lab): ☐ Yes ☐ No

3. 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:** _____

4. Member has a Worst Itch Numerical Rating Scale (WI-NRS) of ≥7 points (0-10 scale): ☐ Yes ☐ No

   WI-NRS score: _____

5. Member has 20 or more nodular lesions: ☐ Yes ☐ No

   Number of nodular lesions: _____

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

LIMITATIONS:

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

Initial authorization will be issued for 6 months.

☐ CONTINUATION OF THERAPY

☐ **Atopic dermatitis*:***

1. 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
2. Annual specialist consult attached if prescriber is not a specialist: ☐ Yes ☐ No ☐ N/A - prescriber is specialist.
3. Provider attests that member **will not** use Dupixent® concomitantly with other biologics: ☐ Yes ☐ No

☐ **Asthma (applies to both eosinophilic phenotype and corticosteroid dependent):**

1. Member has been adherent to therapy: ☐ Yes ☐ No (will be verified through claims history)
2. 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
3. Annual specialist consult attached if prescriber is not a specialist: ☐ Yes ☐ No ☐ N/A - prescriber is specialist.
4. Provider attests member **will not** use Dupixent® concomitantly with other biologics: ☐ Yes ☐ No

☐ **CRSwNP:**

1. Member has been adherent to therapy and concurrent intranasal corticosteroid (unless contraindicated): ☐ Yes ☐ No (will be verified through claims history)
2. 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

3. Annual specialist consult attached if prescriber is not a specialist: ☐ Yes ☐ No ☐ N/A - prescriber is specialist.
4. Provider attests member **will not** use Dupixent® concomitantly with other biologics: ☐ Yes ☐ No

☐ **EOE:**

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

☐ **Prurigo Nodularis:**

1. Member has been adherent to therapy: ☐ Yes ☐ No (will be verified through claims history)
2. 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: _____
3. Annual specialist consult attached if prescriber is not a specialist: ☐ Yes ☐ No ☐ N/A - prescriber is specialist.
4. Provider attests 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 Drug Prior Authorization Unit at 1-800-294-1350.

02/2024