



Please complete ALL information below and fax your request to 1-888-671-5285

### Dupixent® Prior Authorization Request Form (Page 1 of 2)

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Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information <small>(required)</small>					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if <b>generic substitution</b> is acceptable			Directions for Use:		
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>					
Clinical Information <small>(required)</small>					
<b>Select the diagnosis below:</b> <input type="checkbox"/> Moderate to severe asthma <input type="checkbox"/> Moderate to severe chronic atopic dermatitis <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
<b>Prescriber's Specialty:</b> Select if Dupixent is prescribed by or in consultation with one of the following specialists: <input type="checkbox"/> Dermatologist <input type="checkbox"/> Allergist/immunologist					
<b>For moderate to severe asthma, answer the following:</b> Is the patient currently dependent on oral corticosteroids for the treatment of asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have asthma of eosinophilic phenotype as defined by baseline (pre-Dupixent treatment) peripheral blood eosinophil level greater than or equal to 150 cells per microliter within the past 6 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient had at least one or more asthma exacerbations requiring systemic corticosteroids within the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient had any prior intubation for an asthma exacerbation? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient had prior asthma-related hospitalization within the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No Select if the patient is <b>being treated</b> or has <b>contraindication</b> or <b>intolerance</b> to the following: <input type="checkbox"/> High-dose inhaled corticosteroid (ICS) (e.g., greater than 500 mcg fluticasone propionate equivalent/day) <input type="checkbox"/> Additional asthma controller medication (e.g., leukotriene receptor antagonist, long-acting beta-2 agonist [LABA], theophylline) <input type="checkbox"/> One maximally-dosed combination ICS/LABA product (e.g., Advair [fluticasone propionate/salmeterol], Dulera [mometasone/formoterol], Symbicort [budesonide/formoterol])					
<b>Reauthorization:</b> Is there documentation the patient has had a positive clinical response to Dupixent therapy (e.g., reduction in exacerbations)? <input type="checkbox"/> Yes <input type="checkbox"/> No Select if the patient is <b>being treated</b> or has <b>contraindication</b> or <b>intolerance</b> to the following: <input type="checkbox"/> High-dose inhaled corticosteroid (ICS) (e.g., greater than 500 mcg fluticasone propionate equivalent/day) <input type="checkbox"/> Additional asthma controller medication (e.g., leukotriene receptor antagonist, long-acting beta-2 agonist [LABA], theophylline) <input type="checkbox"/> One maximally-dosed combination ICS/LABA product (e.g., Advair [fluticasone propionate/salmeterol], Dulera [mometasone/formoterol], Symbicort [budesonide/formoterol])					

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## Dupixent<sup>®</sup> Prior Authorization Request Form (Page 2 of 2)

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**For moderate to severe chronic atopic dermatitis, answer the following:**

Has the patient had trial and failure, contraindication, or intolerance to ONE medium to high potency topical corticosteroid?  Yes  No

Select if the patient has had trial and failure or intolerance to the following, unless the patient is not a candidate for the therapy (e.g., immunocompromised):

- Elidel (pimecrolimus) topical cream
- Tacrolimus topical ointment

**Reauthorization:**

Is there documentation the patient has had a positive clinical response to Dupixent therapy (e.g., reduction in body surface area involvement, reduction in pruritus severity)?  Yes  No

**Quantity Limit Requests:**

What is the quantity requested per MONTH? \_\_\_\_\_

**What is the reason for exceeding the plan limitations?**

- Titration or loading dose purposes
- Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- Requested strength/dose is not commercially available
- Other: \_\_\_\_\_

**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

Please note: This request may be denied unless all required information is received.