

Dupixent® (Dupilumab) Prior Authorization Form

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

Drug Information

Pharmacy billing (NDC: _____) Fill Date: _____

Dose: _____ Regimen: _____

Pharmacy 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: (Page 1 of 5—please complete and return ALL pages)

1. Please indicate diagnosis:

- Chronic Spontaneous Urticaria (CSU)
- Eosinophilic Esophagitis (EoE)
- Prurigo Nodularis (PN)
- Bullous Pemphigoid (BP)
- Moderate-to-Severe Atopic Dermatitis
- Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP)
- Chronic Obstructive Pulmonary Disease (COPD)
- Moderate-to-Severe Eosinophilic Phenotype Asthma
- Oral Corticosteroid-Dependent Asthma
- 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 **Chronic Spontaneous Urticaria (CSU)**, please provide the following (*Initial approvals will be for the duration of 6 months*):

A. Have other forms of urticaria been ruled out? Yes No

B. Member's Urticaria Activity Score (UAS): _____ Date assessed: _____

C. Does member have a trial of a second-generation H1 antihistamine dosed 4 times the maximum FDA dose within the last 3 months?? Yes No

i. If "Yes", please provide the medication used, dose prescribed, and dates of use:

Medication: _____ Dose: _____ Dates of use: _____

ii. If the second generation H1 antihistamine trial duration was less than 4 weeks, please provide a reason why a 4-week trial is not appropriate for this member: _____

(Page 1 of 5)

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® 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.

CONFIDENTIALITY NOTICE

This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.

Dupilent® (Dupilumab) Prior Authorization Form

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

Clinical Information

Page 2 of 5—Please complete and return all pages. Failure to complete all pages will result in processing delays.

3. 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 the presence of clinical symptoms of EoE ≥ 2 times per week (i.e., dysphagia, emesis, epigastric pain)? Yes No
 - B. Does the member have intraepithelial eosinophilia [≥ 15 eosinophils per high-power field (eol/hpf) in the esophagus]? Yes No
 - C. Has the member failed 1 high-dose proton pump inhibitor or 1 swallowed 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 high-dose proton pump inhibitors or swallowed respiratory corticosteroids? Yes No
 - a. If yes, please describe: _____
4. 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: _____

(Page 2 of 5)

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® 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.

CONFIDENTIALITY NOTICE

This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.

Dupilixent® (Dupilumab) Prior Authorization Form

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

Clinical Information

Page 3 of 5—Please complete and return all pages. Failure to complete all pages will result in processing delays.

5. If diagnosis is **Bullous Pemphigoid (BP)**, please provide the following (*Initial approvals will be for the duration of 6 months*):
- A. Have all other potential causes and/or diagnoses with a similar presentation to BP been ruled out?
Yes No
 - B. Member's Bullous Pemphigoid Disease Area Index (BPDAI) activity score: _____
 - C. Member's Worst-Itch Numeric Rating Scale (WI-NRS) score: _____
 - D. Will member be using dupilumab in combination with a tapering course of oral corticosteroids as outlined in the package labeling? Yes No
 - i. If no, is there a contraindication or documented intolerance? Yes No
 - a. If yes, please describe: _____
 - E. Has the member failed a medium potency to very-high potency 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 topical corticosteroids? Yes No
 - a. If yes, please describe: _____
 - F. Has the member failed an oral 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 oral corticosteroids? Yes No
 - a. If yes, please describe: _____
 - G. Has the member failed an immunosuppressive agent (e.g., methotrexate, azathioprine, mycophenolate, cyclophosphamide)? 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 immunosuppressive agents?
Yes No
 - a. If yes, please describe: _____
 - H. Has the member failed an oral antibiotic agent (e.g., doxycycline, dapsone)? 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 oral antibiotic agents? Yes No
 - a. If yes, please describe: _____

(Page 3 of 5)

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® 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.

CONFIDENTIALITY NOTICE

This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.

Dupixent® (Dupilumab) Prior Authorization Form

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

Clinical Information

Page 4 of 5—Please complete and return all pages. Failure to complete all pages will result in processing delays.

6. 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. Member's body surface area (BSA) of atopic dermatitis involvement: _____
 - C. 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: _____
 - D. 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: _____
7. 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: _____

(Page 4 of 5)

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® 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.

CONFIDENTIALITY NOTICE

This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.

Dupixent® (Dupilumab) Prior Authorization Form

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

Clinical Information

Page 5 of 5—Please complete and return all pages. Failure to complete all pages will result in processing delays.

8. If diagnosis is **Chronic Obstructive Pulmonary Disease (COPD)**, please provide the following (*Initial approvals will be for the duration of 6 months*):
- Will Dupixent® be used as add-on maintenance treatment for inadequately controlled COPD?
Yes No
 - Is member symptomatic [i.e., modified Medical Research Council (mMRC) dyspnea scale grade ≥ 2 , COPD Assessment Test (CAT) ≥ 10] ? Yes No
 - Blood eosinophil count: _____ Date Determined: _____
 - Has member experienced ≥ 2 moderate exacerbations (e.g., required treatment with systemic corticosteroids and/or antibiotics or ≥ 1 severe exacerbation (e.g., required hospitalization or 24-hour observation in emergency room or urgent care) in the last 12 months? Yes No
 - If yes, please provide dates of exacerbations: _____
 - Is member inadequately controlled on triple therapy combination (LABA/LAMA/ICS) used compliantly within the last 3-6 consecutive months? Yes No
 - If yes, please provide drug/dose: _____
 - If no, is there a contraindication? Yes No
 - If yes, please provide details: _____
9. 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*):
- Will this medication be used as add-on maintenance treatment? Yes No
 - If yes, please indicate member's daily medications and dose prescribed for treatment of this diagnosis:
Drug/Dose: _____ Drug/Dose: _____
 - Baseline blood eosinophil count: _____ Date Determined: _____
 - Does member require daily systemic corticosteroids despite compliant use of high-dose inhaled corticosteroid (ICS) plus at least one additional controller medication? Yes No
 - If no, please list number and dates of exacerbations requiring systemic corticosteroids within last 12 months: Number: _____ Dates of exacerbations: _____
 - Please check all that apply:
 - Member has failed a medium to high-dose ICS used compliantly within the last 3-6 consecutive months.
- Drug/Dose: _____
 - Member has failed at least 1 other asthma controller medication used in addition to the medium to high-dose ICS compliantly for at least the past 3 months.
- Drug/Dose: _____
- For Continued Authorization:**
- Is member compliant with therapy? Yes No
 - Is member responding well to therapy? Yes No
 - If member's diagnosis includes Chronic Spontaneous Urticaria, please provide member's current Urticaria Activity Score (UAS): _____ Date assessed: _____
 - If there has been no improvement in member's UAS score, please provide additional clinical information to support the continuation of Dupixent® treatment: _____

(Page 5 of 5)

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.

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® 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.

CONFIDENTIALITY NOTICE
This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.