Dupixent

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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Patient's Name: _____ Date: _____
Patient's ID: _____ Patient's Date of Birth: _____
Physician's Name: _____
Specialty: _____ NPI#: _____
Physician Office Telephone: _____ Physician Office Fax: _____

1. What is the diagnosis?
   - ❑ Atopic dermatitis, moderate-to-severe
   - ❑ Asthma, moderate-to-severe
   - ❑ Chronic rhinosinusitis with nasal polyposis
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. What is the dose being prescribed?
   A) Initial dose (i.e., loading dose): _____ mg
   B) Maintenance dose (i.e., continuation of therapy): _____ mg every other week
4. Is Dupixent being prescribed by or in consultation with any of the following:
   - ❑ Allergist/Immunologist
   - ❑ Otolaryngologist
   - ❑ Dermatologist
   - ❑ Other _____

Section A: Atopic Dermatitis

5. Is the request for continuation of therapy with Dupixent? ❑ Yes ❑ No
6. Is the patient currently receiving Dupixent through samples or a manufacturer's patient assistance program?
   ❑ Yes ❑ No ❑ Unknown
7. Has the patient achieved or maintained positive clinical response as evidenced by low disease activity (i.e., clear or almost clear skin) or improvement in signs and symptoms of atopic dermatitis (e.g., redness, itching, oozing/crusting) since starting treatment with Dupixent? ❑ Yes ❑ No
8. What is the percentage of body surface area (BSA) affected prior to initiation of Dupixent? _____ % of BSA
   ACTION REQUIRED: If 10% or greater, attach supporting chart note(s) or medical record indicating affected body surface area.

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 Dupixent Enhanced SGM - 7/2020.

9. *If less than 10% of BSA is affected,* are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected? ***ACTION REQUIRED: If Yes, please attach supporting chart note(s) or medical record indicating affected area(s).*** ❑ Yes ❑ No

10. Has the patient had an inadequate treatment response to at least TWO medium or higher potency topical corticosteroids in the past 180 days? ***ACTION REQUIRED: If Yes, please attach supporting chart note(s) or medical record showing drug names, dosage form and strength.*** ❑ Yes ❑ No
    If Yes, specify the names of the topical corticosteroids and skip to #14:
    a) _____ b) _____

11. Is the use of topical corticosteroids not advisable for the patient? ❑ Yes ❑ No

12. Has the patient had an inadequate treatment response to topical tacrolimus (Protopic) in the past 180 days? ***ACTION REQUIRED: Please attach patient's chart or medical record to support.***
    If Yes, no further questions. ❑ Yes ❑ No

13. Is the use of topical tacrolimus (Protopic) not advisable for the patient? ❑ Yes ❑ No

14. Is the patient currently receiving Dupixent? ❑ Yes ❑ No

Section B: Asthma

15. Will the patient receive Dupixent as monotherapy (i.e., without any other asthma medications such as inhaled corticosteroids)? ❑ Yes ❑ No

16. Will the patient receive Dupixent concomitantly with other biologics indicated for asthma (e.g., Cinqair, Fasenra, Nucala or Xolair)? ❑ Yes ❑ No

17. Is the request for continuation of therapy with Dupixent? ❑ Yes ❑ No *If No, skip to #23*

18. Is the patient currently receiving Dupixent through samples or a manufacturer's patient assistance program?
    If Yes or Unknown, skip to #20 ❑ Yes ❑ No ❑ Unknown

19. Has the patient achieved and maintained positive clinical response with Dupixent therapy for asthma as evidenced by at least one of the following? *No further questions*
    ❑ A reduction in the frequency and/or severity of symptoms and exacerbations
    ❑ A reduction in the daily maintenance oral corticosteroid dose
    ❑ None of the above

20. Prior to Dupixent therapy, what was the patient's baseline (e.g., before significant oral steroid use) blood eosinophil count in cells per microliter? ***ACTION REQUIRED: Please attach supporting chart note(s) or medical record with the patient's baseline blood eosinophil count.*** _____ cells per microliter
    ❑ Unknown *If less than 150 cells per microliter or Unknown, skip to #22.*

21. Prior to receiving Dupixent, did the patient have inadequate asthma control (e.g. hospitalization or emergency medical care visit within the past year) despite treatment for at least 3 months with both of the following medications at optimized doses: ❑ Yes ❑ No *No further questions*
    a) Medium-to-high-dose inhaled corticosteroid
    b) Additional controller (long acting $beta_2$-agonist, leukotriene modifier, or sustained-release theophylline)

22. Prior to receiving Dupixent, did the patient have inadequate asthma control (e.g. hospitalization or emergency medical care visit within the past year) despite concomitant treatment with all of the following medications at optimized doses: ***ACTION REQUIRED: If Yes, please attach supporting chart note(s) or medical record showing patient's oral glucocorticoid use history, including drug, dose, frequency and duration.***
    If Yes, skip to #26 ❑ Yes ❑ No
    a) High-dose inhaled corticosteroid
    b) Additional controller (long acting $beta_2$-agonist, leukotriene modifier, or sustained-release theophylline)
    c) Oral glucocorticoids (at least 5 mg per day of prednisone/prednisolone or equivalent)

23. What is the patient's baseline (e.g., before significant oral steroid use) blood eosinophil count in cells per microliter? ***ACTION REQUIRED: Please attach supporting chart note(s) or medical record with the patient's pre-treatment blood eosinophil count.*** _____ cells per microliter ❑ Unknown
If less than 150 cells per microliter or Unknown, skip to #25

24. Does the patient have inadequate asthma control (e.g. hospitalization or emergency medical care visit within the past year) despite treatment for at least 3 months with both of the following medications at optimized doses? ***ACTION REQUIRED: Please attach patient's chart or medical record to support.***
If Yes, skip to #31 ❑ Yes ❑ No
a) Medium-to-high-dose inhaled corticosteroid
b) Additional controller (long acting beta$_2$-agonist, leukotriene modifier, or sustained-release theophylline)

25. Does the patient have inadequate asthma control (e.g. hospitalization or emergency medical care visit within the past year) despite concomitant treatment with all of the following medications at optimized doses? ***ACTION REQUIRED: If Yes, please attach supporting chart note(s) or medical record showing treatment regimens, including drug names, dose, frequency and duration.*** ❑ Yes ❑ No
a) High-dose inhaled corticosteroid
b) Additional controller (long acting beta$_2$-agonist, leukotriene modifier, or sustained-release theophylline)
c) Oral glucocorticoids (at least 5 mg per day of prednisone/prednisolone or equivalent)

26. Has the patient received treatment with the inhaled corticosteroid and additional controller for at least 3 months? ❑ Yes ❑ No

27. Has the patient received treatment with oral glucocorticoids for most days during the previous 6 months (e.g. 50% of days, 3 steroid bursts in the previous 6 months)? ***ACTION REQUIRED: Please attach patient's chart or medical record to support.*** ❑ Yes ❑ No

28. Is the patient currently receiving Dupixent? ❑ Yes ❑ No

Section C: Chronic Rhinosinusitis with Nasal Polyposis

29. Is the request for continuation of therapy with Dupixent? ❑ Yes ❑ No *If No, skip to #32*

30. Is the patient currently receiving Dupixent through samples or a manufacturer's patient assistance program?
If Yes or Unknown, skip #32 ❑ Yes ❑ No ❑ Unknown

31. Has the patient achieved or maintained positive clinical response as evidenced by improvement in signs and symptoms of CRSwNP (e.g., improvement in nasal congestion, nasal polyp size, loss of smell, anterior or posterior rhinorrhea, sinonasal inflammation, hyposmia and/or facial pressure or pain or reduction in corticosteroid use)? ❑ Yes ❑ No *No further questions*

32. Does the patient have bilateral nasal polyposis and chronic symptoms of sinusitis? ❑ Yes ❑ No

33. Has the patient had intranasal corticosteroid treatment for at least 2 months? *If Yes, skip to #35* ❑ Yes ❑ No

34. Are intranasal corticosteroids contraindicated or not tolerated? ❑ Yes ❑ No

35. Has the patient had prior sino-nasal surgery? *If Yes, skip to #38* ❑ Yes ❑ No

36. Has the patient had an inadequate response with systemic corticosteroids within the last two years?
If Yes, skip to #38 ❑ Yes ❑ No

37. Are systemic corticosteroids contraindicated or not tolerated? ❑ Yes ❑ No

38. Has the patient had a bilateral nasal endoscopy or anterior rhinoscopy showing polyps reaching below the lower border of the middle turbinate or beyond in each nostril? ***ACTION REQUIRED: If Yes, please attach supporting chart note(s) or medical record showing endoscopy or rhinoscopy details (e.g., polyps location, size).***
❑ Yes ❑ No

39. Does the patient have nasal obstruction? ❑ Yes ❑ No

40. Does the patient have rhinorrhea (anterior/posterior) or reduction or loss of smell? ❑ Yes ❑ No

41. Will the patient be using a daily intranasal corticosteroid while being treated with Dupixent? ❑ Yes ❑ No

State Step Therapy

1. Is the requested drug being used for an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)? ❑ Yes ❑ No

2. Does the prescribed quantity fall within the manufacturer's published dosing guidelines or within dosing guidelines found in the compendia of current literature (examples: package insert, AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)? ❑ Yes ❑ No

3. Does the patient reside in Maryland? ❑ Yes ❑ No *If No, skip to #7*

4. Is the alternate drug (Nucala and Xolair) FDA-approved for the medical condition being treated? ❑ Yes ❑ No *If No, please specify:* _____

5. Has the prescriber provided proof, documented in the patient's chart notes, indicating that the requested drug was ordered for the patient in the past 180 days? ❑ Yes ❑ No *If No, skip to #7*

6. Has the prescriber provided proof, documented in the patient chart notes, that in their opinion the requested drug is effective for the patient's condition? ❑ Yes ❑ No *No further questions*

7. Are any of the following conditions met for the alternate drug (Nucala and Xolair)?
   ❑ The alternate drug is contraindicated
   ❑ The alternate drug is likely to cause an adverse reaction, physical or mental harm
   ❑ The alternate drug is expected to be ineffective
   ❑ The alternate drug was previously tried or a drug in the same class or with the same action was previously tried and was stopped due to ineffectiveness or an adverse event
   ❑ The alternate drug is not in the patient's best interest
   ❑ The alternate drug was tried while covered by the current or the previous health benefit plan
   ❑ None of the above
   If Yes, please specify: _____

8. Is the patient stable or currently receiving a positive therapeutic outcome with the requested drug and a change in the prescription drug is expected to be ineffective or cause harm to the patient? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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