CVS caremark™ **{{PANUMCODE}}**

Dupixent AD Enhanced

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: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, NPI#: _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

1. What is the prescribed dose and frequency?

   a) Loading dose:

   ❑ Dupixent 100 mg Quantity and Frequency: _____
   ❑ Dupixent 200 mg Quantity and Frequency: _____
   ❑ Dupixent 300 mg Quantity and Frequency: _____
   ❑ Other: _____

   b) Maintenance dose:

   ❑ Dupixent 100 mg Quantity and Frequency: _____
   ❑ Dupixent 200 mg Quantity and Frequency: _____
   ❑ Dupixent 300 mg Quantity and Frequency: _____
   ❑ Other: _____

2. What is the diagnosis? *Select all that apply.*

   ❑ Atopic dermatitis, moderate-to-severe ❑ Asthma, moderate-to-severe
   ❑ Eosinophilic esophagitis ❑ Chronic rhinosinusitis with nasal polyposis
   ❑ Prurigo Nodularis ❑ Other _____

3. What is the ICD-10 code? _____

4. What is the patient's weight? _____ kg or lbs ***(Circle one)***

5. Will the requested drug be used in combination with any other biologic (e.g., Adbry, Humira), or targeted synthetic drug (e.g., Rinvoq, Olumiant, Otezla, Xeljanz)? ❑ Yes ❑ No

6. Is the requested drug being prescribed by or in consultation with any of the following?

   ❑ Yes - Allergist/Immunologist ❑ Yes - Gastroenterologist ❑ Yes - Otolaryngologist
   ❑ Yes - Pulmonologist ❑ Yes - Dermatologist ❑ No - None of the above

7. Is this request for continuation of therapy with the requested drug?

   ❑ Yes ❑ No *If No, skip to diagnosis section.*

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

8. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? ❑ Yes ❑ No ❑ Unknown

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Atopic Dermatitis

Continuation

9. Has the patient achieved or maintained a 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 the requested drug? ***ACTION REQUIRED: If Yes, please attach chart note(s) or medical record documentation supporting positive clinical response.*** ❑ Yes ❑ No

Initiation

10. What is the percentage of body surface area (BSA) affected prior to initiation of the requested medication? ***ACTION REQUIRED: Please attach supporting chart note(s) or medical record indicating affected areas and body surface area.*** _____ % of BSA *If greater than or equal to 10% of BSA, skip to #12.*

11. 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

12. Has the patient had an inadequate treatment response with a high potency to super-high potency topical corticosteroid in the past 180 days? ❑ Yes ❑ No *If Yes, please indicate the active ingredient, strength, and dosage form of the high potency to super-high potency topical steroid the patient had an inadequate treatment response to in the last 180 days and skip to #14:*_____

13. Is the use of high potency to super-high potency topical corticosteroids not advisable for the patient (e.g., due to contraindications, prior intolerances, potency not appropriate for member's age)? ***ACTION REQUIRED: If Yes, please attach chart note(s) or medical record documentation of clinical reason to avoid therapy.*** ❑ Yes ❑ No

14. Has the patient had an inadequate treatment response to a topical calcineurin inhibitor in the past 180 days? ***ACTION REQUIRED: If Yes, please attach chart note(s), medical record or claims history supporting prerequisite therapies including drug name, dosage form, strength, and response to therapy.*** *If Yes, no further questions.* ❑ Yes ❑ No

15. Is the use of topical calcineurin inhibitors not advisable for the patient (e.g., due to contraindications or prior intolerances)? ***ACTION REQUIRED: If Yes, please attach chart note(s) or medical record documentation of clinical reason to avoid therapy.*** ❑ Yes ❑ No

Section B: Asthma

Continuation

16. Has asthma control improved on Dupixent treatment, as demonstrated by at least one of the following? ***ACTION REQUIRED: If Yes, please attach supporting chart notes or medical record documentation of improved asthma control.***
    - ❑ 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

17. Will the patient continue to use maintenance asthma treatments (e.g., inhaled corticosteroid, additional controller) in combination with Dupixent? ❑ Yes ❑ No

Initiation

18. Does the patient have uncontrolled asthma as demonstrated by experiencing two or more asthma exacerbations requiring oral or injectable corticosteroid treatment within the past year? ***ACTION REQUIRED: If Yes, please submit supporting chart notes, medical records, or claims history of previous corticosteroid use for asthma exacerbations and skip to #21.*** ❑ Yes ❑ No

19. Does the patient have uncontrolled asthma as demonstrated by experiencing one or more asthma exacerbation(s) resulting in hospitalization or emergency medical care visit within the past year? ***ACTION REQUIRED: If Yes, please submit supporting chart notes, medical records of previous asthma exacerbations requiring hospitalization or emergency medical visit and skip to #21.*** ❑ Yes ❑ No

20. Does the patient have uncontrolled asthma as demonstrated by experiencing poor symptom control (frequent symptoms or reliever use, activity limited by asthma, night waking due to asthma) within the past year? ***ACTION REQUIRED: If Yes, please submit supporting chart notes or medical records showing poor symptom control.*** ❑ Yes ❑ No

21. 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: If Yes, 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 #23.*

22. Prior to receiving Dupixent, did the patient have inadequate asthma control despite current treatment with both of the following medications at optimized doses? ***ACTION REQUIRED: If Yes, please attach supporting chart notes, medical records, or claims history of previous medications tried including drug, dose, frequency, and duration.*** *If Yes, skip to #26* ❑ Yes ❑ No
a) Medium-to-high-dose inhaled corticosteroid
b) Additional controller (i.e., long acting beta$_2$-agonist, long acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline)

23. Prior to receiving Dupixent, did the patient have inadequate asthma control despite concomitant treatment with all of the following medications at optimized doses? ***ACTION REQUIRED: If Yes, please attach supporting chart notes, medical records, or claims history of previous medications tried including drug, dose, frequency, and duration.*** ❑ Yes ❑ No
a) High-dose inhaled corticosteroid
b) Additional controller (i.e., long acting beta$_2$-agonist, long acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline)
c) Oral glucocorticoids (at least 5 mg per day of prednisone/prednisolone or equivalent)

24. Has the patient received treatment with the inhaled corticosteroid and additional controller for at least the previous 3 months? ***ACTION REQUIRED: If Yes, please attach supporting chart notes, medical records, or claims history of previous medications tried including drug, dose, frequency, and duration.*** ❑ Yes ❑ No

25. 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: If Yes, please attach chart notes, medical records, or claim history of oral glucocorticoid use in the previous 6 months.*** ❑ Yes ❑ No

26. Will the patient continue to use maintenance asthma treatments (e.g., inhaled corticosteroid, additional controller) in combination with Dupixent? ❑ Yes ❑ No

27. Does the patient have co-morbid moderate-to-severe atopic dermatitis? ❑ Yes ❑ No

<u>Section C: Chronic Rhinosinusitis with Nasal Polyposis</u>
Continuation

28. 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)? ***ACTION REQUIRED: If Yes, please attach supporting chart notes, medical record documentation of positive clinical response.*** ❑ Yes ❑ No

Initiation

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

30. Has the patient had intranasal corticosteroid treatment for at least 2 months? ***ACTION REQUIRED: If Yes, please attach supporting chart notes, medical records, or claims history of previous medications tried and skip to #32.*** ❑ Yes ❑ No

31. Are intranasal corticosteroids contraindicated or not tolerated? ***ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy.*** ❑ Yes ❑ No

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

33. Has the patient had an inadequate response with systemic corticosteroids within the last two years? ***ACTION REQUIRED: If Yes, please attach supporting chart notes, medical records, or claims history of previous medications tried and skip to #35.*** ❑ Yes ❑ No

34. Are systemic corticosteroids contraindicated or not tolerated? ***ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy.*** ❑ Yes ❑ No

35. Has the patient had a bilateral nasal endoscopy, anterior rhinoscopy, or computed tomography (CT) showing polyps reaching below the lower border of the middle turbinate or beyond in each nostril? ***ACTION REQUIRED: If Yes, please attach supporting chart notes or medical records of endoscopy or rhinoscopy details (e.g., polyps location, size) and skip to #38.*** ❑ Yes ❑ No

36. Has the patient had a Meltzer Clinical Score of 2 or higher in both nostrils? ***ACTION REQUIRED: If Yes, please submit chart notes or medical records of Meltzer Clinical score and skip to #38.*** ❑ Yes ❑ No

37. Has the patient had a total endoscopic nasal polyps score (NPS) of at least 5 with a minimum score of 2 for each nostril? ***ACTION REQUIRED: If Yes, please submit chart notes or medical records of endoscopic nasal polyps score.*** ❑ Yes ❑ No

38. Does the patient have nasal blockage? ❑ Yes ❑ No

39. Does the patient have rhinorrhea (anterior/posterior), reduction or loss of smell, or facial pain or pressure? ❑ Yes ❑ No

40. Will the patient continue to use a daily intranasal corticosteroid while being treated with Dupixent? *If Yes, skip to #42* ❑ Yes ❑ No

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

42. Does the patient have co-morbid moderate-to-severe asthma? ❑ Yes ❑ No

Section D: Eosinophilic Esophagitis

Continuation

43. Has the patient achieved or maintained positive clinical response as evidenced by improvement in signs and symptoms of eosinophilic esophagitis (e.g., dysphagia, heartburn, chest pain, emesis)? ***ACTION REQUIRED: If Yes, please attach supporting chart notes or medical record documentation of positive clinical response.*** ❑ Yes ❑ No

Initiation

44. Does the patient have a history of an average of at least 2 episodes of dysphagia (with intake of solids) per week? ❑ Yes ❑ No

45. Is the diagnosis confirmed by esophageal biopsy as characterized by 15 or more intraepithelial esophageal eosinophils per high power field? ***ACTION REQUIRED: If Yes, please attach supporting chart notes or medical record documentation of endoscopic biopsy details including esophageal eosinophil count.*** ❑ Yes ❑ No

46. Does the member have an inadequate response to proton pump inhibitor? ***ACTION REQUIRED: If Yes, please attach supporting chart notes, medical records, or claims history of previous medications tried.*** ❑ Yes ❑ No

47. Does the member have an inadequate response to systemic corticosteroid and/or local therapies (e.g., budesonide, fluticasone [powder or suspension for inhalation] swallowed)? ***ACTION REQUIRED: If Yes, please attach supporting chart notes, medical records, or claims history of previous medications tried and no further questions.*** ❑ Yes ❑ No

48. Are systemic corticosteroids and local therapies (e.g., budesonide, fluticasone [powder or suspension for inhalation] swallowed) contraindicated or not tolerated? ***ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy.*** ❑ Yes ❑ No

Section E: Prurigo Nodularis

Continuation

49. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity of prurigo nodularis (e.g., clear or almost clear skin) since starting treatment with the requested drug? ***ACTION REQUIRED: If Yes, please attach chart note(s) or medical record documentation supporting positive clinical response.*** *If Yes, no further questions.* ❑ Yes ❑ No

50. Has the patient had a reduction in pruritis intensity and improvement in extent and severity of nodular lesions of prurigo nodularis since starting treatment with the requested drug? ***ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation supporting positive clinical response.*** ❑ Yes ❑ No

Initiation

51. Does the patient have pruritus lasting at least 6 weeks? ***ACTION REQUIRED: If Yes, please attach chart note(s) or medical record of pruritis symptoms.*** ❑ Yes ❑ No

52. Does the patient have history or signs of repeated itch-scratch cycle (e.g., scratching, picking, or rubbing)? ❑ Yes ❑ No

53. Does the patient have a minimum of 20 nodular lesions? ***ACTION REQUIRED: If Yes, please attach chart note(s) or medical record of the presence of nodular lesions.*** ❑ Yes ❑ No

54. Has the patient had an inadequate treatment response with a medium potency to super-high potency topical corticosteroid? *If Yes, skip to #58* ❑ Yes ❑ No

55. Has the patient had an inadequate treatment response to a topical calcineurin inhibitor? ***ACTION REQUIRED: If Yes, please attach chart note(s), medical record, or claims history supporting prerequisite therapies, including response to therapy.*** ❑ Yes ❑ No

56. Has the patient had an inadequate treatment response to phototherapy (e.g., UVB, PUVA)? ***ACTION REQUIRED: If Yes, please attach chart note(s), medical record, or claims history supporting prerequisite therapies, including response to therapy.*** ❑ Yes ❑ No

57. Has the patient had an inadequate treatment response to pharmacologic treatment with methotrexate or cyclosporine? ***ACTION REQUIRED: If Yes, please attach chart note(s), medical record, or claims history supporting prerequisite therapies tried, including response to therapy.***
❑ Yes ❑ No *If No, skip to #59*

58. Please indicate the active ingredient, strength, and dosage form of the medium to super-high potency topical steroid the patient had an inadequate treatment response to: _____
ACTION REQUIRED: Please attach chart note(s), medical record, or claims history supporting prerequisite therapies including drug name, dosage form, strength, and response to therapy. *No further questions.*

59. Has the patient had an intolerance or a clinical reason to avoid medium to super-high potency topical corticosteroids? ***ACTION REQUIRED: If Yes, please attach chart note(s) or medical record supporting intolerance or clinical reason to avoid medium to super-high potency topical corticosteroids.***
❑ Yes ❑ No *If No, skip to #61*

60. Has the patient had an intolerance or a clinical reason to avoid topical calcineurin inhibitors? ***ACTION REQUIRED: If Yes, please attach chart note(s) or medical record supporting intolerance or clinical reason to avoid therapy.*** ❑ Yes ❑ No

61. Has the patient had an intolerance or a clinical reason to avoid pharmacologic treatment with methotrexate and cyclosporine? ***ACTION REQUIRED: Please attach supporting chart note(s) or medical record showing intolerance or clinical reason to avoid methotrexate and cyclosporine.*** ❑ Yes ❑ No

62. Please indicate the clinical reason to avoid pharmacologic treatment with methotrexate and cyclosporine.
    - ❑ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease
    - ❑ Drug interaction
    - ❑ Risk of treatment-related toxicity
    - ❑ Pregnancy or currently planning pregnancy
    - ❑ Breastfeeding
    - ❑ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension)
    - ❑ Hypersensitivity
    - ❑ History of intolerance or adverse event
    - ❑ Other _____

APPENDIX: Relative potency of select topical corticosteroid products

Potency	Drug	Dosage form	Strength
I. Super-high potency (group 1)	Augmented betamethasone dipropionate	Ointment, Lotion, Gel	0.05%
	Clobetasol propionate	Cream, Gel, Ointment, Solution, Cream (emollient), Lotion, Shampoo, Foam, Spray	0.05%
	Fluocinonide	Cream	0.1%
	Flurandrenolide	Tape	4 mcg/cm^2
	Halobetasol propionate	Cream, Lotion, Ointment, Foam	0.05%
II. High potency (group 2)	Amcinonide	Ointment	0.1%
	Augmented betamethasone dipropionate	Cream	0.05%
	Betamethasone dipropionate	Ointment	0.05%
	Clobetasol propionate	Cream	0.025%
	Desoximetasone	Cream, Ointment, Spray	0.25%
		Gel	0.05%
	Diflorasone diacetate	Ointment, Cream (emollient)	0.05%
	Fluocinonide	Cream, Ointment, Gel, Solution	0.05%
	Halcinonide	Cream, Ointment	0.1%
	Halobetasol propionate	Lotion	0.01%
Potency	**Drug**	**Dosage form**	**Strength**
III. High potency (group 3)	Amcinonide	Cream, Lotion	0.1%
	Betamethasone dipropionate	Cream, hydrophilic emollient	0.05%
	Betamethasone valerate	Ointment	0.1%
		Foam	0.12%
	Desoximetasone	Cream, Ointment	0.05%
	Diflorasone diacetate	Cream	0.05%
	Fluocinonide	Cream, aqueous emollient	0.05%
	Fluticasone propionate	Ointment	0.005%
	Mometasone furoate	Ointment	0.1%
	Triamcinolone acetonide	Cream, Ointment	0.5%
IV. Medium potency (group 4)	Betamethasone dipropionate	Spray	0.05%
	Clocortolone pivalate	Cream	0.1%
	Fluocinolone acetonide	Ointment	0.025%
	Flurandrenolide	Ointment	0.05%
	Hydrocortisone valerate	Ointment	0.2%

Potency	Drug	Dosage form	Strength
	Mometasone furoate	Cream, Lotion, Solution	0.1%
	Triamcinolone acetonide	Cream	0.1%
		Ointment	0.05% and 0.1%
		Aerosol Spray	0.2 mg per 2-second spray
V. Lower-mid potency (group 5)	Betamethasone dipropionate	Lotion	0.05%
	Betamethasone valerate	Cream	0.1%
	Desonide	Ointment, Gel	0.05%
	Fluocinolone acetonide	Cream	0.025%
	Flurandrenolide	Cream, Lotion	0.05%
	Fluticasone propionate	Cream, Lotion	0.05%
	Hydrocortisone butyrate	Cream, Lotion, Ointment, Solution	0.1%
	Hydrocortisone probutate	Cream	0.1%
	Hydrocortisone valerate	Cream	0.2%
	Prednicarbate	Cream (emollient), Ointment	0.1%
	Triamcinolone acetonide	Lotion	0.1%
		Ointment	0.025%
VI. Low potency (group 6)	Alclometasone dipropionate	Cream, Ointment	0.05%
	Betamethasone valerate	Lotion	0.1%
	Desonide	Cream, Lotion, Foam	0.05%
	Fluocinolone acetonide	Cream, Solution, Shampoo, Oil	0.01%
	Triamcinolone acetonide	Cream, lotion	0.025%
VII. Least potent (group 7)	Hydrocortisone (base, less than 2%)	Cream, Ointment, Solution	2.5%
		Lotion	2%
		Cream, Ointment, Gel, Lotion, Spray, Solution	1%
		Cream, Ointment	0.5%
	Hydrocortisone acetate	Cream	2.5%
		Lotion	2%
		Cream	1%

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)**

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

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