

Member Name: {{MEMFIRST}} {{MEMLAST}} DOB: {{MEMBERDOB}} PA Number: {{PANUMBER}}



[[PANUMCODE]]

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: {{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 dose being prescribed?
A) Initial dose (i.e., loading dose): _____ mg
B) Maintenance dose (i.e., continuation of therapy): _____ mg every other week
2. What is the diagnosis?
 Atopic dermatitis, moderate-to-severe Asthma
 Chronic rhinosinusitis with nasal polyposis Other _____
3. What is the ICD-10 code? _____
4. Is the patient currently receiving Dupixent? Yes No

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

Section A: Atopic Dermatitis

5. Is the request for continuation of therapy with Dupixent? Yes No *If No, skip to #8*
6. Is the patient currently receiving Dupixent through samples or a manufacturer's patient assistance program?
If Yes or Unknown, skip to #8 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 *No further questions.*
8. What is the percentage of body surface area (BSA) affected prior to initiation of Dupixent? _____ %
If greater than or equal to 10% of BSA, skip to #10.
9. Are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected?
 Yes No
10. To which topical therapies, if any, has the patient had an inadequate treatment response in the past 180 days?
ACTION REQUIRED: If Yes, please attach supporting chart note(s) or medical record showing drug name, dosage form and strength. List continues on next page.
 Topical corticosteroid
 Topical calcineurin inhibitor, *no further questions*
 Both a topical corticosteroid and a topical calcineurin inhibitor, *no further questions*

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None of the above, skip to #12

11. What is the potency of the highest-potency topical corticosteroid the patient has tried in the past 180 days?
If high potency or super-high potency topical steroid was tried, please indicate the active ingredient, strength, and dosage form of the high potency or super-high potency topical steroid that was tried and no further questions.
- Least potent
 Low potency
 Lower-mid potency
 Medium potency
 High potency - *active ingredient, strength, and dosage form:* _____
 Super high potency - *active ingredient, strength, and dosage form:* _____
12. Is the use of high-potency or super-high potency topical corticosteroids and topical calcineurin inhibitors not advisable for the patient (e.g., due to contraindications or prior intolerances)? Yes No

Section B: Asthma

13. The preferred products for your patient's health plan are Nucala and Xolair. Can the patient's treatment be switched to a preferred product? *If Yes, please call 1-866-814-5506 to have the updated form faxed to your office OR you may complete the PA electronically (ePA). You may sign up online via CoverMyMeds at: www.covermymeds.com/epa/caremark/ or call 1-866-452-5017.*
- Yes - Nucala Yes - Xolair No - Continue request for Dupixent
14. Is this request for continuation of therapy with the requested product? Yes No *If No, skip to #16*
15. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer Yes. Yes No *If No, skip to #20*
16. What is the patient's eosinophil count? _____ cells per micro liter
If less than 150 cells per microliter, skip to #18.
17. Does the patient have a documented inadequate response or intolerable adverse event to treatment with Nucala? **ACTION REQUIRED: If Yes, attach supporting chart note(s).** Yes No *If No, complete this form in its entirety and State Step Therapy section.*
18. What is the patient's pretreatment serum IgE level? _____ IU/mL *If less than 30 IU/mL, skip to #20*
19. Does the patient have a documented inadequate response or intolerable adverse event to treatment with Xolair? **ACTION REQUIRED: If Yes, attach supporting chart note(s).** Yes No *If No, complete this form in its entirety and State Step Therapy section.*
20. Will the patient receive Dupixent as monotherapy (i.e., without any other asthma medications such as inhaled corticosteroids)? Yes No
21. Will the patient receive Dupixent concomitantly with other biologics indicated for asthma (e.g., Cinqair, Fasenra, Nucala or Xolair)? Yes No
22. Is the request for continuation of therapy with Dupixent? Yes No *If No, skip to #28*
23. Is the patient currently receiving Dupixent through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to #25* Yes No Unknown
24. Has asthma control improved on Dupixent treatment, as demonstrated by at least one of the following?
Indicate below and 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
25. 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 #27*

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26. Prior to receiving Dupixent, did the patient have inadequate asthma control (e.g. hospitalization or emergency medical care visit within the past year) despite current treatment with both of the following medications at optimized doses? Yes No *No further questions.*
A) Inhaled corticosteroid
B) Additional controller (long acting beta₂-agonist, leukotriene modifier, or sustained-release theophylline)
27. 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 and skip to #31.*** Yes No
A) High-dose inhaled corticosteroid
B) Additional controller (long acting beta₂-agonist, leukotriene modifier, or sustained-release theophylline)
C) Oral glucocorticoids (at least 5 mg per day of prednisone/prednisolone or equivalent)
28. 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 baseline blood eosinophil count.*** _____ cells per microliter Unknown *If less than 150 cells per microliter or unknown, skip to #30*
29. Does the patient have inadequate asthma control (e.g. hospitalization or emergency medical care visit within the past year) despite current treatment with both of the following medications at optimized doses:
 Yes No *No further questions.*
A) Inhaled corticosteroid
B) Additional controller (long acting beta₂-agonist, leukotriene modifier, or sustained-release theophylline)
30. 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 patient's oral glucocorticoid use history, including drug, dose, frequency and duration. Yes No
A) High-dose inhaled corticosteroid
B) Additional controller (long acting beta₂-agonist, leukotriene modifier, or sustained-release theophylline)
C) Oral glucocorticoids (at least 5 mg per day of prednisone/prednisolone or equivalent)
31. Has the patient received treatment with the inhaled corticosteroid and additional controller for at least the previous 3 months? Yes No
32. 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)? Yes No

Section C: Chronic Rhinosinusitis with Nasal Polyposis

33. Is the request for continuation of therapy with Dupixent? Yes No *If No, skip to #36*
34. Is the patient currently receiving Dupixent through samples or a manufacturer's patient assistance program?
If Yes or Unknown, skip to #36 Yes No Unknown
35. 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.*
36. Are intranasal corticosteroids contraindicated or not tolerated? Yes No
37. Does the patient have bilateral nasal polyposis and chronic symptoms of sinusitis? Yes No
38. Has the patient had intranasal corticosteroid treatment for at least 2 months? Yes No
39. Has the patient had prior sino-nasal surgery? *If Yes, skip to #42* Yes No

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40. Has the patient had an inadequate response with systemic corticosteroids within the last two years?
If Yes, skip to #42 Yes No
41. Are systemic corticosteroids contraindicated or not tolerated? Yes No
42. 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
43. Does the patient have nasal obstruction? Yes No
44. Does the patient have rhinorrhea (anterior/posterior) or reduction or loss of smell? Yes No
45. 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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