

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 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: _____
2. What is the diagnosis? *Indicate ALL that apply.*
 - Moderate-to-severe atopic dermatitis
 - Moderate-to severe asthma
 - Chronic rhinosinusitis with nasal polyposis
 - Other _____
3. What is the ICD-10 code? _____
4. Please indicate the patient's weight (in kilograms): _____
5. Is Dupixent being prescribed by or in consultation with any of the following?
 - Allergist/Immunologist
 - Pulmonologist
 - Otolaryngologist
 - Dermatologist
 - Other _____

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

Section A: Atopic Dermatitis

6. Will the patient receive Dupixent concomitantly with other biologics or JAK inhibitors indicated for atopic dermatitis? Yes No
7. Is the request for continuation of therapy with Dupixent? Yes No *If No, skip to #10*
8. Is the patient currently receiving Dupixent through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to #10* Yes No Unknown
9. 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? **ACTION REQUIRED: If Yes, please attach supporting chart note(s) showing that the patient has experienced a positive clinical response to therapy as evidenced by low disease activity or improvement in signs or symptoms.** Yes No *No further questions*
10. What is the percentage of body surface area (BSA) affected prior to initiation of Dupixent? _____ % of BSA **ACTION REQUIRED: Please attach supporting chart note(s) or medical record indicating affected areas and body surface area.** *If greater than or equal to 10% of BSA, skip to #12*
11. *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
12. Has the patient had an inadequate treatment response to at least TWO medium to super-high potency topical corticosteroids used daily for at least 4 weeks in the past 180 days? **ACTION REQUIRED: If Yes, please attach supporting chart note(s) or medical record and claims history showing drug names, dosage form, strength, dosage, duration, and response to therapy.** Yes No
If Yes, indicate the active ingredient, strength, and dosage form of at least TWO medium to super-high potency topical steroids tried by the patient and skip to #14:
a) _____ b) _____
13. Is the use of topical corticosteroids not advisable for the patient? **ACTION REQUIRED: If Yes, please attach supporting documentation of why therapy is not advisable.** Yes No
14. Has the patient had an inadequate treatment response to topical tacrolimus (Protopic) used twice daily for at least 6 weeks in the past 180 days? **ACTION REQUIRED: Please attach patient's chart or medical record and claims history including dosage, duration, and response to therapy.** *If Yes, no further questions* Yes No
15. Is the use of topical tacrolimus (Protopic) not advisable for the patient? **ACTION REQUIRED: If Yes, please attach supporting documentation of why therapy is not advisable.** Yes No

Section B: Asthma

16. Does the patient have co-morbid moderate-to-severe atopic dermatitis? Yes No
17. Will the patient receive Dupixent concomitantly with other biologics indicated for asthma (e.g., Cinqair, Fasenna, Nucala or Xolair)? Yes No
18. Will the patient receive Dupixent as monotherapy (i.e., without any other asthma medications such as inhaled corticosteroids)? Yes No
19. Is this request for continuation of therapy with Dupixent? Yes No *If No, skip to #22*
20. Is the patient currently receiving Dupixent through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to #22* Yes No Unknown

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

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21. Has the patient achieved and maintained positive clinical response with Dupixent therapy for asthma as evidenced by at least one of the following? **ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of positive clinical response.**
- Yes - A reduction in the frequency and/or severity of symptoms and exacerbations
 - Yes - A reduction in the daily maintenance oral corticosteroid dose
 - No - None of the above
22. 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 #24*
23. 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? **ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history of previous medications tried including drug, dose, frequency, and duration and no further questions.** Yes No
- a.) Medium-to-high-dose inhaled corticosteroid
 - a1) Adult and adolescent members (12 years age and older): greater than 250 microgram total daily dose of fluticasone propionate or equivalent
 - a2) Pediatric members (6 to 11 years of age): greater than 100 microgram total daily dose of fluticasone propionate or equivalent
 - b.) Additional controller (long acting beta₂-agonist, leukotriene modifier, or sustained-release theophylline)
24. 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 chart notes, medical record documentation, or claims history of previous medications tried including drug, dose, frequency, and duration.** Yes No
- a) High-dose inhaled corticosteroid
 - a1) Adult and adolescent members (12 years age and older): greater than 500 microgram total daily dose of fluticasone propionate or equivalent
 - a2) Pediatric members (6 to 11 years of age): greater than 200 microgram total daily dose of fluticasone propionate or equivalent
 - 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)
25. Has the patient received treatment with the inhaled corticosteroid and additional controller for at least 3 months? Yes No
26. 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

27. Does the patient have co-morbid moderate-to-severe asthma? Yes No
28. Is the request for continuation of therapy with Dupixent? Yes No *If No, skip to #31*
29. Is the patient currently receiving Dupixent through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip #31* Yes No Unknown
30. 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 chart notes or medical record documentation of positive clinical response.** Yes No *No further questions*
31. Does the patient have bilateral nasal polyposis and chronic symptoms of sinusitis? Yes No

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32. Has the patient had intranasal corticosteroid treatment for at least 2 months? **ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history of previous medications tried and skip to #34** Yes No
33. Are intranasal corticosteroids contraindicated or not tolerated? **ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy.** Yes No
34. Has the patient had prior sino-nasal surgery? *If Yes, skip to #37* Yes No
35. Has the patient had an inadequate response with systemic corticosteroids within the last two years? **ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history of previous medications tried and skip to #37** Yes No
36. Are systemic corticosteroids contraindicated or not tolerated? **ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy.** Yes No
37. 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
38. Does the patient have nasal blockage? Yes No
39. Does the patient have rhinorrhea (anterior/posterior) or reduction or loss of smell? Yes No
40. Will the patient be using a daily intranasal corticosteroid while being treated with Dupixent? *If Yes, no further questions* Yes No
41. Are intranasal corticosteroids contraindicated or not tolerated? 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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