Prior Authorization Request Form for
Dupilumab (Dupixent)

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth _____ Secure Fax #: _____

Step 2 **Please complete the clinical assessment:**

1. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for Dupixent*	☐ **Yes** (subject to verification) **proceed to question 2**	☐ **No** **proceed to question 9**
2. For which indication is the requested medication being prescribed?	☐ moderate to severe or uncontrolled atopic dermatitis - **proceed to question 3** ☐ moderate to severe asthma with an eosinophilic phenotype or with oral corticosteroid dependent asthma - **proceed to question 4** ☐ chronic rhinosinusitis with nasal polyposis - **proceed to question 5** ☐ eosinophilic esophagitis (EoE) – **proceed to question 6** ☐ **Other - STOP Coverage not approved**	
3. Has the patient's disease severity improved and stabilized to warrant continued therapy?	☐ **Yes** **Sign and date below**	☐ **No** **STOP** **Coverage not approved**
4. Has the patient had a positive response to therapy with a decrease in exacerbations, improvements in FEV1, or decrease in oral corticosteroid use?	☐ **Yes** **Sign and date below**	☐ **No** **STOP** **Coverage not approved**

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5. Is there evidence of effectiveness as documented by a decrease in nasal polyps score (NPS) or nasal congestion score (NC)?	☐ **Yes** **Sign and date below**	☐ **No** **STOP** **Coverage not approved**
6. Is the medication being used for maintenance or relapse for the diagnosis of Eosinophilic Esophagitis (EoE)?	☐ Maintenance **proceed to question 7**	☐ Relapse **proceed to question 8**
7. Has the patient experienced a beneficial clinical response, defined by ONE of the following: • **Reduced intraepithelial eosinophil count; OR** • **Decreased dysphagia/pain upon swallowing; OR** • **Reduced frequency/severity of food impaction; OR** • **Reduced vomiting/regurgitation; OR improvement in oral aversion/failure to thrive?**	☐ **Yes** **Sign and date below**	☐ **No** **STOP** **Coverage not approved**
8. Is there a prior authorization form or chart notes documenting a relapse after treatment was discontinued since last approval?	☐ **Yes** **Sign and date below**	☐ **No** **STOP** **Coverage not approved**
9. For which indication is the requested medication being prescribed?	☐ moderate to severe or uncontrolled atopic dermatitis - **proceed to question 10** ☐ moderate to severe asthma with an eosinophilic phenotype or with oral corticosteroid dependent asthma - **proceed to question 11** ☐ chronic rhinosinusitis with nasal polyposis - **proceed to question 12** ☐ eosinophilic esophagitis (EoE) – **proceed to question 29** ☐ **Other - STOP** **Coverage not approved**	
10. Is the patient 6 months of age or older?	☐ **Yes** **proceed to question 13**	☐ **No** **STOP** **Coverage not approved**
11. Is the patient 6 years of age or older?	☐ **Yes** **proceed to question 14**	☐ **No** **STOP** **Coverage not approved**
12. Is the patient 18 years of age or older?	☐ **Yes** **proceed to question 20**	☐ **No** **STOP** **Coverage not approved**
13. Is the requested medication being prescribed by a dermatologist, allergist, or immunologist?	☐ **Yes** **proceed to question 21**	☐ **No** **STOP** **Coverage not approved**
14. Is the requested medication being prescribed by a pulmonologist, asthma specialist, allergist, or immunologist?	☐ **Yes** **proceed to question 15**	☐ **No** **STOP** **Coverage not approved**

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15. For which indication is the requested medication being prescribed?	☐ Moderate to severe asthma with an eosinophilic phenotype –**proceed to question 16** ☐ Oral corticosteroid dependent asthma – **proceed to question** 17	
16. Does the patient have baseline eosinophils GREATER than or EQUAL to 150 cells/mcL?	☐ **Yes** **proceed to question 18**	☐ **No** **STOP** **Coverage not approved**
17. Has the patient required at least 1 month of daily oral corticosteroid use within the past 3 months?	☐ **Yes** **proceed to question 28**	☐ **No** **STOP** **Coverage not approved**
18. Is the patient's asthma uncontrolled despite adherence to optimized medication therapy regimen as defined as requiring one of the following: • **Hospitalization for asthma in past year** • **Two courses of oral corticosteroids in past year,OR** • **Daily high-dose inhaled corticosteroids with inability to taper off of the inhaled corticosteroids?**	☐ **Yes** **proceed to question 19**	☐ **No** **STOP** **Coverage not approved**
19. Has the patient tried and failed an adequate course (3 months) of TWO of the following while using a high-dose inhaled corticosteroid: • **Long-acting beta agonist (LABA, such as Serevent, Striverdi)** • **Long-acting muscarinic antagonist (LAMA, such as Spiriva, Incruse), or Leukotriene receptor antagonist (such as Singulair, Accolate, Zyflo)?**	☐ **Yes** **proceed to question 28**	☐ **No** **STOP** **Coverage not approved**
20. Is the requested medication being prescribed by an allergist, immunologist, pulmonologist, or otolaryngologist?	☐ **Yes** **proceed to question 23**	☐ **No** **STOP** **Coverage not approved**

21. Does the patient have a contraindication to, intolerability to, or have they failed treatment with ONE medication in EACH of the following two categories: • **Topical Corticosteroids AND** NOTE: **For patients 18 years of age or older,** high potency/class 1 topical corticosteroids (for example, clobetasol propionate 0.05% ointment/cream, fluocinonide 0.05% ointment/cream) is required. **For patients 6 months to 17 year of age**, topical corticosteroids can be any topical corticosteroid, including low potency steroids. • **Topical calcineurin inhibitor (for example, pimecrolimus, tacrolimus)?** NOTE: Topical calcineurin inhibitor is required for **patients 2 years of age and older**. The requirement of topical calcineurin inhibitors does not apply to patients less than 2 years of age.	☐ **Yes** **proceed to question 22**	☐ **No** **STOP** **Coverage not approved**
22. Does the patient have a contraindication to, intolerability to, inability to access treatment, or have they failed treatment with Narrowband UVB phototherapy?	☐ **Yes** **proceed to question 28**	☐ **No** **STOP** **Coverage not approved**
23. Is the presence of nasal polyposis confirmed by imaging or direct visualization?	☐ **Yes** **proceed to question 24**	☐ **No** **STOP** **Coverage not approved**
24. Does the patient have at least two of the following symptoms: mucopurulent discharge, nasal obstruction and congestion, decreased or absent sense of smell, or facial pressure and pain?	☐ **Yes** **proceed to question 25**	☐ **No** **STOP** **Coverage not approved**
25. Will Dupixent be only used as add-on therapy to standard treatments, including nasal steroids and nasal saline irrigation?	☐ **Yes** **proceed to question 26**	☐ **No** **STOP** **Coverage not approved**
26. Has the symptoms of chronic rhinosinusitis with nasal polyposis been inadequately controlled using the following treatments: • **Adequate duration of at least two different high-dose intranasal corticosteroids** • **AND nasal saline irrigation, AND past surgical history or endoscopic surgical intervention or has a contraindication to surgery?**	☐ **Yes** **proceed to question 27**	☐ **No** **STOP** **Coverage not approved**

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27. Will the patient be using the 300 mg strength?	☐ **Yes** **proceed to question 28**	☐ **No** **STOP** **Coverage not approved**
28. Is the patient taking any other immunobiologics (for example, benralizumab [Fasenra], mepolizumab [Nucala], or omalizumab [Xolair])	☐ **Yes** **STOP** **Coverage not approved**	☐ **No** **Sign and date below**
29. Is the patient 12 years of age or older?	☐ **Yes** **proceed to question 30**	☐ **No** **STOP** **Coverage not approved**
30. Does the patient weigh at least 40 kilograms (88 lbs)?	☐ **Yes** **proceed to question 31**	☐ **No** **STOP** **Coverage not approved**
31. Is the requested medication being prescribed by or in consultation with a gastroenterologist or allergy/immunology specialist?	☐ **Yes** **proceed to question 32**	☐ **No** **STOP** **Coverage not approved**
32. Does the patient have a documented diagnosis of Eosinophilic Esophagitis (EoE) by endoscopic biopsy?	☐ **Yes** **proceed to question 33**	☐ **No** **STOP** **Coverage not approved**

33. Has the patient tried and failed an adequate course of both the following: • **Proton pump inhibitor (PPI) at up to maximally indicated doses (adults: 20-40 mg twice daily omeprazole equivalent; children: 1-2mg/kg or equivalent), unless contraindicated or clinically significant adverse effects are experienced AND** • **Topical glucocorticoids [such as fluticasone (Flovent), budesonide (Pulmicort)] at up to maximally indicated doses, unless contraindicated, clinically significant adverse effects are experienced, or in children maximal doses cannot be reached due to concerns for growth suppression or adrenal insufficiency?**	☐ **Yes** **proceed to question 34**	☐ **No** **STOP** **Coverage not approved**
34. Is the patient taking any other immunobiologics (for example, benralizumab [Fasenra], mepolizumab [Nucala], or omalizumab [Xolair])?	☐ **Yes** **STOP** **Coverage not approved**	☐ **No** **Sign and date below**

STEP 3 **I certify the above is true to the best of my knowledge.** Please sign and date.

Prescriber Signature _____ Date _____

[19 April 2023]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: