Prior Authorization Request Form for
Dupilumab (Dupixent)

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

USFHP Pharmacy Prior Authorization Form

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

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

Clinical Documentation must accompany form in order for a determination to be made.

Initial approvals expire after six months, renewal approvals are indefinite. For renewal of therapy an initial Tricare prior authorization approval is required.

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

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth _____ Secure Fax #: _____

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 6**
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** ☐ **Other - STOP Coverage not approved**	
3. Has the patient had a positive response to therapy (for example: an Investigator's Static Global Assessment [ISGA] score of clear [0] or almost clear [1])?	☐ **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 decrease in nasal polyps score (NPS) or nasal congestion score (NC)?	☐ **Yes** **Sign and date below**	☐ **No** **STOP** **Coverage not approved**
6. For which indication is the requested medication being prescribed?	☐ moderate to severe or uncontrolled atopic dermatitis **proceed to question 7** ☐ moderate to severe asthma with an eosinophilic phenotype or with oral corticosteroid dependent asthma **proceed to question 8** ☐ chronic rhinosinusitis with nasal polyposis **proceed to question 9** ☐ **Other - STOP Coverage not approved**	
7. Is the patient 6 years of age or older?	☐ **Yes** **proceed to question 10**	☐ **No** **STOP** **Coverage not approved**
8. Is the patient 12 years of age or older?	☐ **Yes** **SKIP to question 11**	☐ **No** **STOP** **Coverage not approved**
9. Is the patient 18 years of age or older?	☐ **Yes** **SKIP to question 12**	☐ **No** **STOP** **Coverage not approved**
10. Is the requested medication being prescribed by a dermatologist, allergist, or immunologist?	☐ **Yes** **proceed to question 13**	☐ **No** **STOP** **Coverage not approved**
11. Is the requested medication being prescribed by a pulmonologist, asthma specialist, allergist, or immunologist?	☐ **Yes** **proceed to question 16**	☐ **No** **STOP** **Coverage not approved**
12. Is the requested medication being prescribed by or in consultation with an allergist, immunologist, pulmonologist, or otolaryngologist?	☐ **Yes** **proceed to question 20**	☐ **No** **STOP** **Coverage not approved**
13. Does the patient have a contraindication to, intolerability to, or failed treatment with, at least one high potency (class 1) Topical Corticosteroid?	☐ **Yes** **proceed to question 14**	☐ **No** **STOP** **Coverage not approved**
14. Does the patient have a contraindication to, intolerability to, or failed treatment with, at least one systemic immunosuppressant?	☐ **Yes** **proceed to question 15**	☐ **No** **STOP** **Coverage not approved**

15. Does the patient have a contraindication to, intolerability to, inability to access treatment, or failed treatment with Narrowband UVB phototherapy?	☐ **Yes** **Sign and date below**	☐ **No** **STOP** **Coverage not approved**
16. Does the patient have baseline eosinophils greater than or equal to 150 cells/mcL?	☐ **Yes** **proceed to question 17**	☐ **No** **STOP** **Coverage not approved**
17. Has the patients symptoms been adequately controlled on a stable high-dose inhaled corticosteroid AND either an inhaled Long- Acting Beta Agonist or a Leukotriene Receptor Antagonist for at least 3 months?	☐ **Yes** **STOP** **Coverage not approved**	☐ **No** **proceed to question 18**
18. Will Dupixent be used for relief of acute bronchospasm or status asthmaticus?	☐ **Yes** **STOP** **Coverage not approved**	☐ **No** **proceed to question 19**
19. Will Dupixent be used as an adjunct therapy to other asthma controller medications?	☐ **Yes** **Sign and date below**	☐ **No** **STOP** **Coverage not approved**
20. Does the patient have chronic rhinosinusitis with nasal polyposis and is refractory to treatment with other therapies?	☐ **Yes** **proceed to question 21**	☐ **No** **STOP** **Coverage not approved**
21. Has nasal polyposis been confirmed by imaging or direct visualization?	☐ **Yes** **proceed to question 22**	☐ **No** **STOP** **Coverage not approved**
22. Will Dupixent be used as add-on therapy only?	☐ **Yes** **proceed to question 23**	☐ **No** **STOP** **Coverage not approved**
23. Has symptoms of chronic rhinosinusitis with nasal polyposis been adequately controlled using the following treatments; • **Adequate duration of at least two different high-dose intranasal corticosteroids, AND** • **Nasal saline irrigation, AND** • **Two courses of oral corticosteroids in the past year or has a contraindication to oral corticosteroids, AND** • **Past surgical history or endoscopic surgical intervention or has a contraindication to surgery**	☐ **Yes** **STOP** **Coverage not approved**	☐ **No** **proceed to question 24**

24. Is the patient taking any other type-2 allergic immunobiologics (mepolizumab, omalizumab, etc.)?	☐ **Yes** **STOP** **Coverage not approved**	☐ **No** **proceed to question 25**
25. Will the patient be using the 300 mg strength?	☐ **Yes** **Sign and date below**	☐ **No** **STOP** **Coverage not approved**

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

Prescriber Signature _____ Date _____

[30 December 2020]

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