pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

DUPIXENT (dupilumab) PRIOR AUTHORIZATION FORM *(form effective 1/8/2024)*

Prior authorization guidelines for **Dupixent** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested: Dupixent	Strength:	Formulation (pen, syringe, etc):	Weight: _____ lbs / kg	
Directions:			Quantity:	Refills:
Diagnosis (*submit documentation*):			Diagnosis code (*required*):	
Is Dupixent prescribed by or in consultation with a specialist (eg, allergist, dermatologist, hematologist/oncologist, immunologist, pulmonologist, rheumatologist, etc)?			☐Yes ☐No	*Submit documentation of consultation, if applicable.*

Complete the section(s) below applicable to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

INITIAL requests

1. **For treatment of atopic dermatitis:** Which of the following treatments have been tried (or cannot be tried due to intolerance or contraindication) by the beneficiary? *Check all that apply.*
   - ☐At least ONE of the of the following:
     - ☐For the face, skin folds, or other critical areas, a 4-week trial of a low-potency (or higher) topical corticosteroid
     - ☐For other body areas, a 4-week trial of a medium potency or higher topical corticosteroid
   - ☐An 8-week trial of a topical calcineurin inhibitor (eg, pimecrolimus, tacrolimus)

2. **For treatment of asthma:** Indicate which of the following apply to the beneficiary. *Check all that apply.*
   - ☐At least ONE of the following:
     - ☐Has a diagnosis of asthma with an eosinophilic phenotype with an absolute blood eosinophil count ≥ 150 cells/microliter
     - ☐Has a diagnosis of oral corticosteroid-dependent asthma
   - ☐Has asthma that is moderate-to-severe
   - ☐Has tried or cannot use standard asthma controller medications (e.g., inhaled corticosteroids, inhaled long-acting beta agonists [LABAs], etc.)
   - ☐Will use Dupixent in addition to tolerated standard asthma controller medications (e.g., inhaled corticosteroids, inhaled LABAs, etc.)

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3. For treatment of chronic rhinosinusitis with nasal polyposis:
   - ☐ Will use Dupixent as an add-on maintenance treatment for inadequately controlled chronic rhinosinusitis with nasal polyposis

4. For treatment of eosinophilic esophagitis:
   - ☐ Has tried and failed or cannot try (due to intolerance or contraindication) a proton pump inhibitor (eg, omeprazole, lansoprazole, etc)

5. For treatment of prurigo nodularis:
   - ☐ Has a history of pruritis for at least 6 weeks
   - ☐ Has prurigo nodularis associated with at least ONE of the following:
     - ☐ ≥20 nodular lesions
     - ☐ Significant disability or impairment of physical, mental, or psychosocial functioning

6. Other diagnosis – specify: _____

   List other treatments tried (including start/stop dates, dose, outcomes, etc.): _____

   _____

RENEWAL requests

1. For the treatment of asthma:
   - ☐ Has documented measurable evidence of improvement in the beneficiary's asthma
   - ☐ Maintained asthma control while decreasing the oral corticosteroid dose
   - ☐ Continues to use Dupixent in addition to tolerated standard asthma controller medications (e.g., inhaled corticosteroids, inhaled LABAs, etc.)

2. For the treatment of all other diagnoses:
   - ☐ Has documented evidence of improvement in disease severity

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date: