Prior Authorization Request Form for Dupixent

FAX this completed form to (844) 205-3386

OR Mail requests to: Envolve Pharmacy Solutions PA Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720

I. PROVIDER INFORMATION	II. MEMBER INFORMATION
Prescriber Name:	Member Name:
Prescriber Specialty:	Identification #:
Office Contact Name:	Group #:
Group Name:	Date of Birth:
Fax #:	Medication Allergies:
Phone #:	

III. DRUG INFORMATION (One drug request per form)		
Drug name and strength:	Dosage Interval (sig):	Qty. per Day:

IV. REQUIRED DOCUMENTION *(Detailed medical record documentation demonstrating evidence for each item must be submitted with prior authorization request)*

Specify diagnosis & diagnosis code relevant to this request: Dx/Dx Code: _____

- ☐ If not prescribed by one of the following specialist, allergist, dermatologist, rheumatologist, immunologist, pulmonologist, oncologist etc., please indicate a specialist consulted:_____
- ☐ If currently using a different Monoclonal Antibodies – Anti-IL, Anti-IgE, Anti-TSLP agent (Fasenra, Nucala, Xolair, Cinqair, Tezspire) OR Immunomodulator, atopic dermatitis (e.g., Adbry, Cibinqo, Rinvoq), will discontinue the other Monoclonal Antibodies – Anti-IL, Anti-IgE, Anti-TSLP or Immunomodulator, atopic agent prior to starting Dupixent (dupilumab)
- ☐ If requesting for daily quantity exceeding daily limit (Refer to https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx), please provide supporting information:_____

SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.

ASTHMA:

- ☐ Has moderate-to-severe asthma

  One of the following:
  - ☐ Has tried standard asthma controller medications (e.g., inhaled corticosteroids, inhaled long-acting beta agonists [LABAs], etc.) (medication, start date and end date):_____
  - ☐ Has an intolerance or contraindication to standard asthma controller medications (e.g., inhaled corticosteroids, inhaled long-acting beta agonists [LABAs], etc.):_____

  One of the following:
  - ☐ Has absolute blood eosinophil count of at least 150 cells/microL:_____
  - ☐ Is dependent on oral corticosteroids (medication):_____
- ☐ Requested medication will be used with standard asthma controller medications (LABA, LAMA, ICS):_____

ASTHMA RENEWAL REQUESTS:

- ☐ Both of the following:
  - ☐ One of the following:
    - ☐ Documented measurable evidence of improvement in severity of asthma evidenced by: _____
    - ☐ Has a reduction of oral corticosteroid while maintaining asthma control (new dose):_____
  - ☐ Continues to use Dupixent in addition to standard asthma controller medications (LABA, LAMA, ICS):_____

MODERATE-TO-SEVERE CHRONIC ATOPIC DERMATITIS:

- ☐ Has a history of therapeutic failure of at least 2 OR contraindication or intolerance to ALL the following: (medication, start date and end date)
  - ☐ One of the following:
    - ☐ For treatment of the face, skin folds or other critical areas, low-potency topical corticosteroids for at least 4 weeks (medication, start date and end date):_____
    - ☐ For treatment of other areas, medium potency or higher topical corticosteroids for at least 4 weeks (medication, start date and end date):_____
  - ☐ A topical calcineurin inhibitors for at least 8 weeks (medication, start date and end date): _____

MODERATE-TO-SEVERE CHRONIC ATOPIC DERMATITIS RENEWAL REQUESTS:

- ☐ Documented measurement improvement in severity of atopic dermatitis evidenced by:_____

EOSINOPHILIC ESOPHAGITIS:

- ☐ Has a history of therapeutic failure of or a contraindication or an intolerance to a proton pump inhibitor: (medication, start date and end date):_____

EOSINOPHILIC ESOPHAGITIS RENEWAL REQUESTS:

- ☐ Documented measurement improvement in severity of eosinophilic esophagitis evidenced by:_____

CHRONIC RHINOSINUSITIS WITH NASAL POLYPOSIS:

- ☐ Will use Dupixent as an add-on maintenance treatment for inadequately controlled chronic rhinosinusitis with nasal polyposis

CHRONIC RHINOSINUSITIS WITH NASAL POLYPOSIS RENEWAL REQUESTS:

- ☐ Documented measurement improvement in severity of chronic rhinosinusitis with nasal polyposis evidenced by:_____

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

PRURIGO NODULARIS RENEWAL REQUESTS:

- ☐ Documented measurement improvement in severity of prurigo nodularis evidenced by:_____

ALL OTHER DIAGNOSES:

- ☐ Has a history of therapeutic failure of or a contraindication or an intolerance to first line therapies: (medication(s), start and end date(s)):_____

IV. ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION :

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider Signature:	Date:

Envolve Pharmacy Solutions will respond via fax or phone within 24 hours.

Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)