



PRIOR AUTHORIZATION REQUEST FORM

DUPIXENT® for ASTHMA, EOSINOPHILIC ESOPHAGITIS (EoE), or PRURIGO NODULARIS

For authorization, please answer each question and fax this form PLUS chart notes back to Real Rx at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance 385-425-5094.

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:

Height/Weight:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: Dupixent® (dupilumab)

Dosing/Frequency: _____

Note: for the treatment of nasal polyps see Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP), for the treatment of atopic dermatitis see Brand Name Atopic Dermatitis Agents

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is this request for an expedited review? By checking the "Yes" box to request an expedited review (24 hours), you are certifying that applying the standard review time frame (72 hours) may place the member's life, health, or ability to regain maximum function in serious jeopardy.	<input type="checkbox"/>	<input type="checkbox"/>	
ASTHMA			
1. Does the member have a diagnosis of moderate to severe asthma?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
2. Is the request made by, or in consultation with, an allergist, pulmonologist or immunologist?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has the member had a trial and failure of Fasenra® (benralizumab), which requires prior authorization, unless contraindicated?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Has the member been compliant for at least 5 months with high dose inhaled corticosteroid/long acting inhaled beta-2 agonist or with high-dose inhaled corticosteroid and leukotriene receptor antagonist?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. Does the member have poor asthma control with recurrent exacerbations that have required emergency department visits, hospitalizations, or frequent office visits?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
6. Does documentation show that the member's FEV1 is less than 80%?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation

7. Are underlying conditions or triggers for asthma or pulmonary disease being maximally managed (i.e. inhaled respiratory irritants – tobacco, allergen exposure, physical activity, medications, emotional factors, respiratory infections, COPD, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
8. Does the member have a baseline eosinophil count ≥ 300 cells/ μL in the last 6 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
9. Has the member required daily oral corticosteroid therapy for at least the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
EOSINOPHILIC ESOPHAGITIS (EoE)			
1. Does the member have a confirmed diagnosis of EoE with 15 or more intraepithelial eosinophils per high-power field (eos/hpf) from esophageal biopsy and have symptoms of dysphagia?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
2. Is the request made by, or in consultation with, an allergist or a gastroenterologist?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has the member had a trial and failure of the following? <ul style="list-style-type: none"> • Diet modification • Proton-Pump Inhibitor • Topical glucocorticosteroid treatment 	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Does the member weigh more than 40kg?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
PRURIGO NODULARIS (PN)			
1. Is the request made by a provider specializing in dermatology, allergy, or immunology?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the disease involvement rated as moderate to severe?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Has the member tried phototherapy?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Has the member had an adequate trial with at least two moderate to very high potency prescription corticosteroids?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. If unable to tolerate corticosteroids due to the treatment area (e.g. face, genitals, etc.), has the member had an adequate trial with a calcineurin inhibitor such as topical tacrolimus?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
6. Has the member tried cyclosporine or methotrexate within the past 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
REAUTHORIZATION			
ASTHMA			
1. Is the request for reauthorization for asthma therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is there evidence of positive clinical response as defined by documentation demonstrating reduced hospitalization and/or emergency room visits?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
EOSINOPHILIC ESOPHAGITIS (EoE)			
1. Is the request for reauthorization of chronic EoE therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is there evidence of positive clinical response as defined by documentation demonstrating improvement in eos/hpf from baseline and symptoms?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
PRURIGO NODULARIS (PN)			
1. Is the request for reauthorization of prurigo nodularis therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is there evidence of a positive clinical response to therapy?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			

Additional information:

Physician Signature:

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Policy: PHARM-022
Origination Date: 07/12/2017
Reviewed/Revised Date: 01/18/2023
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