US Family Health Plan
Prior Authorization Request Form for
Dupilumab (**Dupixent**)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Initial approvals expire after twelve 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'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. 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** **proceed to question 11**	☐ **No** **STOP** **Coverage not approved**
9. Is the patient 18 years of age or older?	☐ **Yes** **proceed to question 17**	☐ **No** **STOP** **Coverage not approved**
10. Is the requested medication being prescribed by a dermatologist, allergist, or immunologist?	☐ **Yes** **proceed to question 18**	☐ **No** **STOP** **Coverage not approved**
11. Is the requested medication being prescribed by a pulmonologist, asthma specialist, allergist, or immunologist?	☐ **Yes** **proceed to question 12**	☐ **No** **STOP** **Coverage not approved**
12. For which indication is the requested medication being prescribed?	☐ Moderate to severe asthma with an eosinophilic phenotype - **proceed to question 13** ☐ Oral corticosteroid dependent asthma - **proceed to question 14**	
13. Does the patient have baseline eosinophils GREATER than or EQUAL to 150 cells/mcL?	☐ **Yes** **proceed to question 15**	☐ **No** **STOP** **Coverage not approved**
14. Has the patient required at least 1 month of daily oral corticosteroid use within the past 3 months?	☐ **Yes** **proceed to question 25**	☐ **No** **STOP** **Coverage not approved**
15. 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 16**	☐ **No** **STOP** **Coverage not approved**

16. 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 25**	☐ **No** **STOP** **Coverage not approved**
17. 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**
18. 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,** a high potency/class 1 topical corticosteroid (for example, clobetasol propionate 0.05% ointment/cream, fluocinonide 0.05% ointment/cream) is required. **For patients 6 to 17 year of age,** topical corticosteroids can be any topical corticosteroid, including low potency steroids. • **Topical calcineurin inhibitor (for example, pimecrolimus, tacrolimus)**	☐ **Yes** **proceed to question 19**	☐ **No** **STOP** **Coverage not approved**
19. 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 25**	☐ **No** **STOP** **Coverage not approved**
20. Is the presence of nasal polyposis confirmed by imaging or direct visualization?	☐ **Yes** **proceed to question 21**	☐ **No** **STOP** **Coverage not approved**
21. 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 22**	☐ **No** **STOP** **Coverage not approved**
22. Will Dupixent be only used as add-on therapy to standard treatments, including nasal steroids and nasal saline irrigation?	☐ **Yes** **proceed to question 23**	☐ **No** **STOP** **Coverage not approved**

23. 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 24**	☐ **No** **STOP** **Coverage not approved**
24. Will the patient be using the 300 mg strength?	☐ **Yes** **proceed to question 25**	☐ **No** **STOP** **Coverage not approved**
25. 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 _____