USFHP 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

https://www.usfamilyhealth.org/for-providers/pharmacy-information/

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 #:	

Step 2

Please complete the clinical assessment:

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 **4**
2. What is the indication or diagnosis?	☐ 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 **3** ☐ Chronic rhinosinusitis with nasal polyposis - proceed to question **3** ☐ Eosinophilic esophagitis – proceed to question **3** ☐ Prurigo nodularis – proceed to question **3** ☐ Moderate to severe chronic obstructive pulmonary disease - proceed to question **3** ☐ Chronic Spontaneous Urticaria – proceed to question **3** ☐ Chronic Bullous Pemphigoid – proceed to question **3** ☐ Allergic Fungal Rhinosinusitis – proceed to question **3** ☐ Other diagnosis **- 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**

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4. What is the patient's age?	☐ 18 years of age or older –proceed to question **5** ☐ 17 years of age or younger –proceed to question **6**	
5. What is the indication or diagnosis for this adult patient?	☐ Moderate to severe or uncontrolled atopic dermatitis - proceed to question **8** ☐ Moderate to severe asthma with an eosinophilic phenotype or with oral corticosteroid dependent asthma - proceed to question **12** ☐ Chronic rhinosinusitis with nasal polyposis - proceed to question **17** ☐ Eosinophilic esophagitis – proceed to question **24** ☐ Prurigo nodularis – proceed to question **27** ☐ Moderate to severe chronic obstructive pulmonary disease (COPD) - proceed to question **32** ☐ Chronic Spontaneous Urticaria – proceed to question **37** ☐ Bullous Pemphigoid – proceed to question **40** ☐ Allergic Fungal Rhinosinusitis – proceed to question **46** ☐ Other diagnosis **- STOP Coverage not approved**	
6. What is the indication or diagnosis for this pediatric patient?	☐ 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 **11** ☐ Chronic rhinosinusitis with nasal polyposis - proceed to question **16** ☐ Eosinophilic esophagitis – proceed to question **23** ☐ Chronic Spontaneous Urticaria – proceed to question **36** ☐ Allergic Fungal Rhinosinusitis – proceed to question **45** ☐ Other diagnosis **- STOP Coverage not approved**	
7. Is the patient 6 months of age or older?	☐ **Yes** proceed to question **8**	☐ **No** **STOP** **Coverage not approved**
8. Is the requested medication being prescribed by a dermatologist, allergist, or immunologist?	☐ **Yes** proceed to question **9**	☐ **No** **STOP** **Coverage not approved**

9. 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 Corticosteroid: For patients 6 months to 17 years of age**, topical corticosteroids can be any topical corticosteroid, including low potency steroids. **For patients 18 years of age or older**, high potency/class 1 topical corticosteroids (for example, clobetasol propionate 0.05% ointment/cream) is required. • **Topical calcineurin inhibitor: Does not apply to patients less than 2 years of age.**	☐ **Yes** proceed to question **10**	☐ **No** **STOP** **Coverage not approved**
10. 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 **44**	☐ **No** **STOP** **Coverage not approved**
11. Is the patient 6 years of age or older?	☐ **Yes** proceed to question **12**	☐ **No** **STOP** **Coverage not approved**
12. Is the requested medication being prescribed by an allergist, immunologist or pulmonologist?	☐ **Yes** proceed to question **13**	☐ **No** **STOP** **Coverage not approved**
13. For which indication is the requested medication being prescribed?	☐ Moderate to severe asthma with an eosinophilic phenotype (baseline eosinophils greater than or equal to 150 cells/mcL) – proceed to question **14** ☐ Oral corticosteroid dependent asthma requiring at least 1 month of daily oral corticosteroid use within the past 3 months – proceed to question **44**	
14. Is the patient's asthma uncontrolled despite adherence to optimized medication therapy regimen? Uncontrolled asthma is defined as requiring one of the following: Hospitalization for asthma in past year, OR 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 **15**	☐ **No** **STOP** **Coverage not approved**
15. 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)** • **Leukotriene receptor antagonist (such as Singulair, Accolate, Zyflo)**	☐ **Yes** proceed to question **44**	☐ **No** **STOP** **Coverage not approved**
16. Is the patient 12 years of age or older?	☐ **Yes** proceed to question **17**	☐ **No** **STOP** **Coverage not approved**

17. Is the requested medication being prescribed by an allergist, immunologist, pulmonologist, or otolaryngologist?	☐ **Yes** proceed to question **18**	☐ **No** **STOP** **Coverage not approved**
18. Is the presence of nasal polyposis confirmed by imaging or direct visualization?	☐ **Yes** proceed to question **19**	☐ **No** **STOP** **Coverage not approved**
19. 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 **20**	☐ **No** **STOP** **Coverage not approved**
20. Will Dupixent be only used as add-on therapy to standard treatments, including nasal steroids and nasal saline irrigation?	☐ **Yes** proceed to question **21**	☐ **No** **STOP** **Coverage not approved**
21. Have the symptoms of chronic rhinosinusitis with nasal polyposis been inadequately controlled using ALL the following treatments: • **Adequate duration of at least two different high-dose intranasal corticosteroids** • **Nasal saline irrigation** • **Past surgical history or endoscopic surgical intervention or has a contraindication to surgery**	☐ **Yes** proceed to question **22**	☐ **No** **STOP** **Coverage not approved**
22. Will the patient be using the 300 mg strength?	☐ **Yes** proceed to question **44**	☐ **No** **STOP** **Coverage not approved**
23. Is the patient 1 year of age or older and weighs at least 15 kilograms?	☐ **Yes** proceed to question **24**	☐ **No** **STOP** **Coverage not approved**
24. Is the requested medication being prescribed by or in consultation with a gastroenterologist, allergist or immunologist?	☐ **Yes** proceed to question **25**	☐ **No** **STOP** **Coverage not approved**
25. Does the patient have a documented diagnosis of Eosinophilic Esophagitis (EoE) by endoscopic biopsy?	☐ **Yes** proceed to question **26**	☐ **No** **STOP** **Coverage not approved**

26. Has the patient tried and failed an adequate course of BOTH the following: • **Proton pump inhibitor (PPI) at up to maximally indicated doses (adults: 20-40 mg twice daily omeprazole equivalent; children: 1-2mg/kg or equivalent), unless contraindicated or clinically significant adverse effects are experienced** • **Topical glucocorticoids [such as fluticasone (Flovent), budesonide (Pulmicort)] at up to maximally indicated doses, unless contraindicated, clinically significant adverse effects are experienced**	☐ **Yes** proceed to question **44**	☐ **No** **STOP** **Coverage not approved**
27. Is the requested medication being prescribed by a dermatologist, allergist, or immunologist?	☐ **Yes** proceed to question **28**	☐ **No** **STOP** **Coverage not approved**
28. Does the patient have 20 or more identifiable nodular lesions in total on both arms, and/or both legs, and/or trunk?	☐ **Yes** proceed to question **29**	☐ **No** **STOP** **Coverage not approved**
29. Has the patient experienced pruritus for 6 weeks or longer?	☐ **Yes** proceed to question **30**	☐ **No** **STOP** **Coverage not approved**
30. Does the patient have a contraindication to, intolerability to, or has failed treatment with one high potency/class 1 topical corticosteroids (for example, clobetasol propionate 0.05% ointment/cream, fluocinonide 0.05% ointment/cream)?	☐ **Yes** proceed to question **31**	☐ **No** **STOP** **Coverage not approved**
31. Does the patient have a contraindication to, intolerability to, inability to access treatment, or has failed treatment with phototherapy?	☐ **Yes** proceed to question **44**	☐ **No** **STOP** **Coverage not approved**
32. Is the requested medication being prescribed by a pulmonologist?	☐ **Yes** proceed to question **33**	☐ **No** **STOP** **Coverage not approved**
33. Does the patient have moderate to severe chronic obstructive pulmonary disease (COPD) with both chronic bronchitis and an eosinophilic phenotype (GREATER THAN 300 cells/microliter)?	☐ **Yes** proceed to question **34**	☐ **No** **STOP** **Coverage not approved**

34. Does the patient have uncontrolled COPD symptoms despite the use of all of the following: long-acting muscarinic antagonists (for example, Spiriva); long-acting-beta agonists (for example, formoterol); inhaled corticosteroid (for example, budesonide)?	☐ **Yes** proceed to question **35**	☐ **No** **STOP** **Coverage not approved**
35. Is the requested medication being requested for add-on maintenance therapy for management of COPD?	☐ **Yes** proceed to question **44**	☐ **No** **STOP** **Coverage not approved**
36. Is the patient 12 years of age or older?	☐ **Yes** proceed to question **37**	☐ **No** **STOP** **Coverage not approved**
37. Is the requested medication being prescribed by a dermatologist, allergist, or immunologist?	☐ **Yes** proceed to question **38**	☐ **No** **STOP** **Coverage not approved**
38. Does the patient have a diagnosis of chronic spontaneous urticaria with symptoms lasting longer than 6 weeks?	☐ **Yes** proceed to question **39**	☐ **No** **STOP** **Coverage not approved**
39. Has the patient remained symptomatic despite a trial of at least 4 weeks up to 4 times the standard dosing of a second-generation histamine H-1 antihistamine (such as, cetirizine, levocetirizine, loratadine, desloratadine, fexofenadine)?	☐ **Yes** proceed to question **44**	☐ **No** **STOP** **Coverage not approved**
40. Is the requested medication being prescribed by a dermatologist, allergist, or immunologist?	☐ **Yes** proceed to question **41**	☐ **No** **STOP** **Coverage not approved**
41. Does the patient have an initial bullous pemphigoid disease area index (BPDAI) score GREATER THAN OR EQUAL TO 24?	☐ **Yes** proceed to question **42**	☐ **No** **STOP** **Coverage not approved**
42. Does the patient have an initial Peak Pruritus Numeric Rating Scale score of GREATER THAN OR EQUAL TO 4?	☐ **Yes** proceed to question **43**	☐ **No** **STOP** **Coverage not approved**
43. Has the patient failed treatment, have an intolerability to, or has a contraindication to all the following: (a) One high potency/class 1 topical corticosteroid (for example, clobetasol propionate 0.05% ointment/cream), (b) One oral corticosteroid (for example, prednisone, prednisolone), AND (c) Two additional adjuncts (for example, methotrexate, azathioprine, mycophenolate, cyclophosphamide, doxycycline)?	☐ **Yes** proceed to question **44**	☐ **No** **STOP** **Coverage not approved**
44. Is the patient currently receiving another immunobiologic (for example, benralizumab [Fasenra], mepolizumab [Nucala], or omalizumab [Xolair])?	☐ **Yes** **STOP** **Coverage not approved**	☐ **No** **Sign and date below**

45. Is the patient 6 years of age or older?	☐ **Yes** proceed to question **46**	☐ **No** **STOP** **Coverage not approved**
46. Is the requested medication being prescribed by an allergist, immunologist, pulmonologist, or otolaryngologist?	☐ **Yes** proceed to question **47**	☐ **No** **STOP** **Coverage not approved**
47. Does the patient have a past surgical history or endoscopic surgical intervention?	☐ **Yes** proceed to question **49**	☐ **No** proceed to question **48**
48. Does the patient have a contraindication to surgery?	☐ **Yes** proceed to question **49**	☐ **No** **STOP** **Coverage not approved**
49. Are the patient's symptoms inadequately controlled despite topical treatments (for example, but not limited to, corticosteroids, saline irrigation)?	☐ **Yes** proceed to question **50**	☐ **No** **STOP** **Coverage not approved**
50. Will the patient be using the requested medication concomitantly with other targeted immunobiologics, including but not limited to: Tumor Necrosis Factor (TNF) inhibitors, interleukins, Janus Kinase (JAK) inhibitors?	☐ **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