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 USFHP 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 USFHP benefit in the last 6 months? *Please choose "No" if the patient did not previously have a USFHP approved PA for Dupixent*	☐ **Yes** (subject to verification) **proceed to question 2**	☐ **No** **proceed to question 9**
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** ☐ eosinophilic esophagitis (EoE) – **proceed to question 6** ☐ **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**

Prior Authorization Request Form for
Dupilumab (Dupixent)

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. Is the medication being used for maintenance or relapse for the diagnosis of Eosinophilic Esophagitis (EoE)?	☐ Maintenance **proceed to question 7**	☐ Relapse **proceed to question 8**
7. Has the patient experienced a beneficial clinical response, defined by ONE of the following: • **Reduced intraepithelial eosinophil count; OR** • **Decreased dysphagia/pain upon swallowing; OR** • **Reduced frequency/severity of food impaction; OR** • **Reduced vomiting/regurgitation; OR improvement in oral aversion/failure to thrive?**	☐ **Yes** **Sign and date below**	☐ **No** **STOP** **Coverage not approved**
8. Is there a prior authorization form or chart notes documenting a relapse after treatment was discontinued since last approval?	☐ **Yes** **Sign and date below**	☐ **No** **STOP** **Coverage not approved**
9. For which indication is the requested medication being prescribed?	☐ moderate to severe or uncontrolled atopic dermatitis - **proceed to question 10** ☐ 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 12** ☐ eosinophilic esophagitis (EoE) – **proceed to question 29** ☐ **Other - STOP Coverage not approved**	
10. Is the patient 6 months of age or older?	☐ **Yes** **proceed to question 13**	☐ **No** **STOP** **Coverage not approved**
11. Is the patient 6 years of age or older?	☐ **Yes** **proceed to question 14**	☐ **No** **STOP** **Coverage not approved**
12. Is the patient 18 years of age or older?	☐ **Yes** **proceed to question 20**	☐ **No** **STOP** **Coverage not approved**
13. Is the requested medication being prescribed by a dermatologist, allergist, or immunologist?	☐ **Yes** **proceed to question 21**	☐ **STOP** **Coverage not approved**
14. Is the requested medication being prescribed by a pulmonologist, asthma specialist, allergist, or immunologist?	☐ **Yes** **proceed to question 15**	☐ **STOP** **Coverage not approved**

Prior Authorization Request Form for
Dupilumab (Dupixent)

15. For which indication is the requested medication being prescribed?	☐ Moderate to severe asthma with an eosinophilic phenotype –**proceed to question 16** ☐ Oral corticosteroid dependent asthma – **proceed to question** 17	
16. Does the patient have baseline eosinophils GREATER than or EQUAL to 150 cells/mcL?	☐ **Yes** **proceed to question 18**	☐ **No** **STOP** **Coverage not approved**
17. Has the patient required at least 1 month of daily oral corticosteroid use within the past 3 months?	☐ **Yes** **proceed to question 28**	☐ **No** **STOP** **Coverage not approved**
18. 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 19**	☐ **No** **STOP** **Coverage not approved**
19. 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 28**	☐ **No** **STOP** **Coverage not approved**
20. Is the requested medication being prescribed by an allergist, immunologist, pulmonologist, or otolaryngologist?	☐ **Yes** **proceed to question 23**	☐ **No** **STOP** **Coverage not approved**

21. 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,** high potency/class 1 topical corticosteroids (fo rexample, 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 22**	☐ **No** **STOP** **Coverage not approved**
22. 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 28**	☐ **No** **STOP** **Coverage not approved**
23. Is the presence of nasal polyposis confirmed by imaging or direct visualization?	☐ **Yes** **proceed to question 24**	☐ **No** **STOP** **Coverage not approved**
24. 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 25**	☐ **No** **STOP** **Coverage not approved**
25. Will Dupixent be only used as add-on therapy to standard treatments, including nasal steroids and nasal saline irrigation?	☐ **Yes** **proceed to question 26**	☐ **No** **STOP** **Coverage not approved**
26. 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 27**	☐ **No** **STOP** **Coverage not approved**
27. Will the patient be using the 300 mg strength?	☐ **Yes** **proceed to question 28**	☐ **No** **STOP** **Coverage not approved**

28. 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**
29. Is the patient 12 years of age or older?	☐ **Yes** **proceed to question 30**	☐ **No** **STOP** **Coverage not approved**
30. Does the patient weigh at least 40 kilograms (88 lbs)?	☐ **Yes** **proceed to question 31**	☐ **No** **STOP** **Coverage not approved**
31. Is the requested medication being prescribed by or in consultation with a gastroenterologist or allergy/immunology specialist?	☐ **Yes** **proceed to question 32**	☐ **No** **STOP** **Coverage not approved**
32. Does the patient have a documented diagnosis of Eosinophilic Esophagitis (EoE) by endoscopic biopsy?	☐ **Yes** **proceed to question 33**	☐ **No** **STOP** **Coverage not approved**
33. 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 AND** • **Topical glucocorticoids [such as fluticasone (Flovent), budesonide (Pulmicort)] at up to maximally indicated doses, unless contraindicated, clinically significant adverse effects are experienced, or in children maximal doses cannot be reached due to concerns for growth suppression or adrenal insufficiency?**	☐ **Yes** **proceed to question 34**	☐ **No** **STOP** **Coverage not approved**

34. 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 _____