

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

Prurigo Nodularis approvals are indefinite. Initial approvals for other indications expire after 1 year, renewal approvals are indefinite. For renewal of therapy, an initial 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:

<p>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.</p>	<input type="checkbox"/> Yes (subject to verification) proceed to question 2	<input type="checkbox"/> No proceed to question 9
<p>2. For which indication is the requested medication being prescribed?</p>	<input type="checkbox"/> moderate to severe or uncontrolled atopic dermatitis - proceed to question 3 <input type="checkbox"/> moderate to severe asthma with an eosinophilic phenotype or with oral corticosteroid dependent asthma - proceed to question 4 <input type="checkbox"/> chronic rhinosinusitis with nasal polyposis - proceed to question 5 <input type="checkbox"/> eosinophilic esophagitis (EoE) – proceed to question 6 <input type="checkbox"/> Other - STOP Coverage not approved	
<p>3. Has the patient's disease severity improved and stabilized to warrant continued therapy?</p>	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved
<p>4. Has the patient had a positive response to therapy with a decrease in exacerbations, improvements in FEV1, or decrease in oral corticosteroid use?</p>	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved

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<p>5. Is there evidence of effectiveness as documented by a decrease in nasal polyps score (NPS) or nasal congestion score (NC)?</p>	<p><input type="checkbox"/> Yes Sign and date below</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>6. Is the medication being used for maintenance or relapse for the diagnosis of Eosinophilic Esophagitis (EoE)?</p>	<p><input type="checkbox"/> Maintenance proceed to question 7</p>	<p><input type="checkbox"/> Relapse proceed to question 8</p>
<p>7. Has the patient experienced a beneficial clinical response, defined by ONE of the following:</p> <ul style="list-style-type: none"> • 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? 	<p><input type="checkbox"/> Yes Sign and date below</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>8. Is there a prior authorization form or chart notes documenting a relapse after treatment was discontinued since last approval?</p>	<p><input type="checkbox"/> Yes Sign and date below</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>9. For which indication is the requested medication being prescribed?</p>	<p><input type="checkbox"/> moderate to severe or uncontrolled atopic dermatitis - proceed to question 10</p> <p><input type="checkbox"/> moderate to severe asthma with an eosinophilic phenotype or with oral corticosteroid dependent asthma - proceed to question 11</p> <p><input type="checkbox"/> chronic rhinosinusitis with nasal polyposis - proceed to question 12</p> <p><input type="checkbox"/> eosinophilic esophagitis (EoE) – proceed to question 29</p> <p><input type="checkbox"/> prurigo nodularis – proceed to question 35</p> <p><input type="checkbox"/> Other - STOP Coverage not approved</p>	
<p>10. Is the patient 6 months of age or older?</p>	<p><input type="checkbox"/> Yes proceed to question 13</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>11. Is the patient 6 years of age or older?</p>	<p><input type="checkbox"/> Yes proceed to question 14</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>12. Is the patient 18 years of age or older?</p>	<p><input type="checkbox"/> Yes proceed to question 20</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>13. Is the requested medication being prescribed by a dermatologist, allergist, or immunologist?</p>	<p><input type="checkbox"/> Yes proceed to question 21</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>14. Is the requested medication being prescribed by a pulmonologist, asthma specialist, allergist, or immunologist?</p>	<p><input type="checkbox"/> Yes proceed to question 15</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>15. For which indication is the requested medication being prescribed?</p>	<p><input type="checkbox"/> Moderate to severe asthma with an eosinophilic phenotype– proceed to question 16</p> <p><input type="checkbox"/> Oral corticosteroid dependent asthma – proceed to question 17</p>	

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<p>16. Does the patient have baseline eosinophils GREATER than or EQUAL to 150 cells/mcL?</p>	<p align="center"><input type="checkbox"/> Yes proceed to question 18</p>	<p align="center"><input type="checkbox"/> No STOP Coverage not approved</p>
<p>17. Has the patient required at least 1 month of daily oral corticosteroid use within the past 3 months?</p>	<p align="center"><input type="checkbox"/> Yes proceed to question 28</p>	<p align="center"><input type="checkbox"/> No STOP Coverage not approved</p>
<p>18. Is the patient's asthma uncontrolled despite adherence to optimized medication therapy regimen as defined as requiring one of the following:</p> <ul style="list-style-type: none"> • 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? 	<p align="center"><input type="checkbox"/> Yes proceed to question 19</p>	<p align="center"><input type="checkbox"/> No STOP Coverage not approved</p>
<p>19. Has the patient tried and failed an adequate course (3 months) of TWO of the following while using a high-dose inhaled corticosteroid:</p> <ul style="list-style-type: none"> • 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, Zylflo)? 	<p align="center"><input type="checkbox"/> Yes proceed to question 28</p>	<p align="center"><input type="checkbox"/> No STOP Coverage not approved</p>
<p>20. Is the requested medication being prescribed by an allergist, immunologist, pulmonologist, or otolaryngologist?</p>	<p align="center"><input type="checkbox"/> Yes proceed to question 23</p>	<p align="center"><input type="checkbox"/> No STOP Coverage not approved</p>
<p>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:</p> <ul style="list-style-type: none"> • Topical Corticosteroids AND NOTE: For patients 18 years of age or older, high potency/class 1 topical corticosteroids (for example, clobetasol propionate 0.05% ointment/cream, fluocinonide 0.05% ointment/cream) is required. For patients 6 months to 17 year of age, topical corticosteroids can be any topical corticosteroid, including low potency steroids. • Topical calcineurin inhibitor (for example, pimecrolimus, tacrolimus)? NOTE: Topical calcineurin inhibitor is required for patients 2 years of age and older. The requirement of topical calcineurin inhibitors does not apply to patients less than 2 years of age. 	<p align="center"><input type="checkbox"/> Yes proceed to question 22</p>	<p align="center"><input type="checkbox"/> No STOP Coverage not approved</p>
<p>22. Does the patient have a contraindication to, intolerability to, inability to access treatment, or have they failed treatment with Narrowband UVB phototherapy?</p>	<p align="center"><input type="checkbox"/> Yes proceed to question 28</p>	<p align="center"><input type="checkbox"/> No STOP Coverage not approved</p>

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<p>23. Is the presence of nasal polyposis confirmed by imaging or direct visualization?</p>	<p><input type="checkbox"/> Yes proceed to question 24</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>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?</p>	<p><input type="checkbox"/> Yes proceed to question 25</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>25. Will Dupixent be only used as add-on therapy to standard treatments, including nasal steroids and nasal saline irrigation?</p>	<p><input type="checkbox"/> Yes proceed to question 26</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>26. Has the symptoms of chronic rhinosinusitis with nasal polyposis been inadequately controlled using the following treatments:</p> <ul style="list-style-type: none"> •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? 	<p><input type="checkbox"/> Yes proceed to question 27</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>27. Will the patient be using the 300 mg strength?</p>	<p><input type="checkbox"/> Yes proceed to question 28</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>28. Is the patient taking any other immunobiologics (for example, benralizumab [Fasenra], mepolizumab [Nucala], or omalizumab [Xolair])</p>	<p><input type="checkbox"/> Yes STOP Coverage not approved</p>	<p><input type="checkbox"/> No Sign and date below</p>
<p>29. Is the patient 12 years of age or older?</p>	<p><input type="checkbox"/> Yes proceed to question 30</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>30. Does the patient weigh at least 40 kilograms (88 lbs)?</p>	<p><input type="checkbox"/> Yes proceed to question 31</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>31. Is the requested medication being prescribed by or in consultation with a gastroenterologist or allergy/immunology specialist?</p>	<p><input type="checkbox"/> Yes proceed to question 32</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>32. Does the patient have a documented diagnosis of Eosinophilic Esophagitis (EoE) by endoscopic biopsy?</p>	<p><input type="checkbox"/> Yes proceed to question 33</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>

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<p>33. Has the patient tried and failed an adequate course of both the following:</p> <ul style="list-style-type: none"> • 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? 	<p style="text-align: center;"><input type="checkbox"/> Yes proceed to question 34</p>	<p style="text-align: center;"><input type="checkbox"/> No STOP Coverage not approved</p>
<p>34. Is the patient taking any other immunobiologics (for example, benralizumab [Fasenra], mepolizumab [Nucala], or omalizumab [Xolair])?</p>	<p style="text-align: center;"><input type="checkbox"/> Yes STOP Coverage not approved</p>	<p style="text-align: center;"><input type="checkbox"/> No Sign and date below</p>
<p>35. Is the patient 18 years of age or older?</p>	<p style="text-align: center;"><input type="checkbox"/> Yes proceed to question 36</p>	<p style="text-align: center;"><input type="checkbox"/> No STOP Coverage not approved</p>
<p>36. Is the requested medication being prescribed by a dermatologist, allergist, or immunologist?</p>	<p style="text-align: center;"><input type="checkbox"/> Yes proceed to question 37</p>	<p style="text-align: center;"><input type="checkbox"/> No STOP Coverage not approved</p>
<p>37. Does the patient have 20 or more identifiable nodular lesions in total on both arms, and/or both legs, and/or trunk?</p>	<p style="text-align: center;"><input type="checkbox"/> Yes proceed to question 38</p>	<p style="text-align: center;"><input type="checkbox"/> No STOP Coverage not approved</p>
<p>38. Has the patient experienced pruritus for 6 weeks or longer?</p>	<p style="text-align: center;"><input type="checkbox"/> Yes proceed to question 39</p>	<p style="text-align: center;"><input type="checkbox"/> No STOP Coverage not approved</p>
<p>39. Is the patient's prurigo nodularis medication-induced or secondary to a non-dermatologic condition?</p>	<p style="text-align: center;"><input type="checkbox"/> Yes proceed to question 40</p>	<p style="text-align: center;"><input type="checkbox"/> No proceed to question 41</p>
<p>40. Has the secondary cause of prurigo nodularis been identified and adequately managed?</p>	<p style="text-align: center;"><input type="checkbox"/> Yes proceed to question 41</p>	<p style="text-align: center;"><input type="checkbox"/> No STOP Coverage not approved</p>
<p>41. 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)?</p>	<p style="text-align: center;"><input type="checkbox"/> Yes proceed to question 42</p>	<p style="text-align: center;"><input type="checkbox"/> No STOP Coverage not approved</p>

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42. Does the patient have a contraindication to, intolerability to, inability to access treatment, or has failed treatment with phototherapy?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved
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STEP 3 I certify the above is true to the best of my knowledge. Please sign and date.

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Prescriber Signature

Date

[15 Dec 2023]