United Healthcare Community Plan

Dupixent

PRIOR AUTHORIZATION REQUEST FORM

Please complete this entire form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form contains multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information:		

Is the requested medication □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

United Healthcare Community Plan

Dupixent

PRIOR AUTHORIZATION REQUEST FORM

Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

	ALL REQUESTS
□ **Yes** □ **No**	**Does the patient have one of the following diagnoses?** *(If yes, check which applies)* □ Asthma □ Atopic dermatitis □ Chronic obstructive pulmonary disease (COPD) □ Chronic rhinosinusitis with nasal polyposis (CRSwNP) □ Eosinophilic esophagitis □ Prurigo nodularis
□ **Yes** □ **No**	**Is Dupixent prescribed by one of the following?** *(If yes, check which applies)* □ Allergist □ Immunologist □ Dermatologist □ Otolaryngologist □ Gastroenterologist □ Pulmonologist
□ **Yes** □ **No**	**Is the patient receiving Dupixent in combination with any of the following?** *(If yes, check which applies)* □ Anti-IgE (immunoglobulin E) therapy [e.g., Xolair (omalizumab)] □ Anti-interleukin-5 therapy [e.g., Nucala (mepolizumab), Cinqair (resilizumab), Fasenra (benralizumab)] □ Biologic immunomodulator [e.g., Adbry (tralokinumab-ldrm)] □ Janus kinase inhibitor [e.g., Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib), Opzelura (topical ruxolitinib), Cibinqo (abrocitinib)] □ Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]
	ASTHMA
□ **Yes** □ **No**	**Does the patient have moderate-to-severe asthma?**
□ **Yes** □ **No**	**Is the patient's asthma classified as uncontrolled or inadequately controlled as defined by any of the following?** *(If yes, check which applies)* □ Poor symptom control (e.g., Asthma Control Questionnaire [ACQ] score consistently greater than 1.5 or Asthma Control Test [ACT] score consistently less than 20) □ Two or more bursts of systemic corticosteroids for at least 3 days each in the previous 12 months □ Asthma-related emergency treatment (e.g., emergency room visit, hospital admission, or unscheduled physician's office visit for nebulizer or other urgent treatment) □ Airflow limitation (e.g., after appropriate bronchodilator withhold forced expiratory volume in 1 second [FEV1] less than 80% predicted [in the face of reduced FEV1/forced vital capacity [FVC] defined as less than the lower limit of normal]) □ Patient is currently dependent on oral corticosteroids for the treatment of asthma
□ **Yes** □ **No**	**Will the patient use Dupixent in combination with any of the following?** *(If yes, check which applies)* □ One maximally-dosed (appropriately adjusted for age) combination inhaled corticosteroid (ICS)/long-acting beta2 agonist (LABA) [e.g., Advair/AirDuo Respiclick (fluticasone propionate/salmeterol), Symbicort (budesonide/formoterol), Breo Ellipta (fluticasone furoate/vilanterol)] □ One maximally-dosed (appropriately adjusted for age) inhaled corticosteroid (ICS) product [e.g., ciclesonide (Alvesco), mometasone furoate (Asmanex), beclomethasone dipropionate (QVAR)] □ One additional asthma controller medication [e.g., LABA - olodaterol (Striverdi) or indacaterol (Arcapta); leukotriene receptor antagonist – montelukast (Singulair); theophylline]
□ **Yes** □ **No**	**Will medical records (e.g., chart notes, laboratory values, etc.) be submitted documenting that asthma is an eosinophilic phenotype as defined by a baseline (pre-dupilumab treatment) peripheral blood eosinophil level greater than or equal to 150 cells/microliter?** *(MEDICAL RECORDS MUST BE SUBMITTED)*
□ **Yes** □ **No**	**Is the patient currently on Dupixent therapy, as confirmed by submission of medical records?** *(MEDICAL RECORDS MUST BE SUBMITTED)*

United Healthcare Community Plan

Dupixent

PRIOR AUTHORIZATION REQUEST FORM

ASTHMA - REAUTHORIZATION	
□ **Yes** □ **No**	**Is there documentation of positive clinical response to Dupixent therapy as demonstrated by any of the following?** *(If yes, check which applies)* □ Reduction in the frequency of exacerbations □ Decreased utilization of rescue medications □ Increase in percent predicted forced expiratory volume in 1 second (FEV1) from pretreatment baseline □ Reduction in severity or frequency of asthma-related symptoms (e.g., wheezing, shortness of breath, coughing, etc.) □ Reduction in oral corticosteroid requirements
□ **Yes** □ **No**	**Will the patient use Dupixent in combination with any of the following?** *(If yes, check which applies)* □ One maximally-dosed (appropriately adjusted for age) combination inhaled corticosteroid (ICS)/long-acting beta2 agonist (LABA) [e.g., Advair/AirDuo Respiclick (fluticasone propionate/salmeterol), Symbicort (budesonide/formoterol), Breo Ellipta (fluticasone furoate/vilanterol)] □ One maximally-dosed (appropriately adjusted for age) inhaled corticosteroid (ICS) product [e.g., ciclesonide (Alvesco), mometasone furoate (Asmanex), beclomethasone dipropionate (QVAR)] □ One additional asthma controller medication [e.g., LABA - olodaterol (Striverdi) or indacaterol (Arcapta); leukotriene receptor antagonist – montelukast (Singulair); theophylline]
ATOPIC DERMATITIS	
□ **Yes** □ **No**	**Does the patient have moderate-to-severe chronic atopic dermatitis?**
□ **Yes** □ **No**	**Does the patient have <u>failure</u> to any of the following therapeutic classes of topical therapies, as confirmed by submission of medical records?** *(If yes, check which applies. MEDICAL RECORDS MUST BE SUBMITTED)* □ One medium, high, or very-high potency topical corticosteroid [e.g., mometasone furoate (generic Elocon), fluocinolone acetonide (generic Synalar), fluocinonide (generic Lidex)] □ One topical calcineurin inhibitor [e.g., pimecrolimus (generic Elidel), tacrolimus (generic Protopic)] □ Eucrisa (crisaborole)
□ **Yes** □ **No**	**Does the patient have a history of <u>contraindication or intolerance</u> to any of the following therapeutic classes of topical therapies?** *(If yes, check which applies and specify contraindication or intolerance)* □ One medium, high, or very-high potency topical corticosteroid [e.g., mometasone furoate (generic Elocon), fluocinolone acetonide (generic Synalar), fluocinonide (generic Lidex)] _____ _____ □ One topical calcineurin inhibitor [e.g., pimecrolimus (generic Elidel), tacrolimus (generic Protopic)] _____ _____ □ Eucrisa (crisaborole) _____
□ **Yes** □ **No**	**Is the patient currently on Dupixent therapy, as confirmed by submission of medical records?** *(MEDICAL RECORDS MUST BE SUBMITTED)*
ATOPIC DERMATITIS - REAUTHORIZATION	
□ **Yes** □ **No**	**Is there documentation of positive clinical response to Dupixent therapy?**

United Healthcare Community Plan

Dupixent

PRIOR AUTHORIZATION REQUEST FORM

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)	
□ **Yes** □ **No**	**Will documentation (e.g., medical records, chart notes) be submitted showing any of the following?** *(If yes, check which applies. DOCUMENTATION MUST BE SUBMITTED)* □ Post-bronchodilator forced expiratory volume (FEV1) / forced vital capacity (FVC) ratio less than 0.7 □ Post-bronchodilator FEV1 % predicted greater than or equal to 30% and less than or equal to 70% □ Patient has an eosinophilic phenotype defined by a baseline (pre-dupilumab treatment) peripheral blood eosinophil level greater than or equal to 300 cells/μL
□ **Yes** □ **No**	**Does the patient have uncontrolled or inadequately controlled COPD demonstrated by any of the following?** *(If yes, check which applies)* □ Two or more COPD exacerbations in the previous year requiring treatment with systemic corticosteroids and/or antibiotics □ One or more COPD exacerbation(s) that resulted in hospitalization or observation for over 24 hours in an emergency department or urgent care facility in the past year □ COPD exacerbation(s) occurred while receiving maintenance therapy with one of the following: □ Triple therapy with a long-acting muscarinic antagonist (LAMA), long-acting beta agonist (LABA), and inhaled corticosteroid (ICS) (e.g., Breztri Aerosphere, Trelegy Ellipta) □ Dual therapy with a LAMA and LABA (e.g., Anoro Ellipta, Bevespi Aerosphere, Stiolto Respimat) and a failure, contraindication, or intolerance to an inhaled corticosteroid (ICS)
□ **Yes** □ **No**	**Has the patient had symptoms of chronic productive cough for at least 3 months in the past year?**
□ **Yes** □ **No**	**Will the patient use Dupixent as add-on maintenance therapy with any of the following?** *(If yes, check which applies)* □ Triple therapy with a long-acting muscarinic antagonist (LAMA), long-acting beta agonist (LABA), and inhaled corticosteroid (ICS) (e.g., Breztri Aerosphere, Trelegy Ellipta) □ Dual therapy with a LAMA and LABA (e.g., Anoro Ellipta, Bevespi Aerosphere, Stiolto Respimat) and a failure, contraindication, or intolerance to an inhaled corticosteroid (ICS)
CHRONIC OBSTRUCTIVE PULMONARY DISEASE - REAUTHORIZATION	
□ **Yes** □ **No**	**Is there documentation of positive clinical response to Dupixent therapy as demonstrated by any of the following?** *(If yes, check which applies)* □ Reduction in the frequency of COPD exacerbations □ Increase in percent predicted FEV1 from pretreatment baseline □ Reduction in severity or frequency of COPD-related symptoms (e.g., dyspnea, wheezing, cough, sputum volume, decrease in sputum purulence) □ Reduction in oral corticosteroid requirements
□ **Yes** □ **No**	**Will the patient use Dupixent as add-on maintenance therapy with any of the following?** *(If yes, check which applies)* □ Triple therapy with a long-acting muscarinic antagonist (LAMA), long-acting beta agonist (LABA), and inhaled corticosteroid (ICS) (e.g., Breztri Aerosphere, Trelegy Ellipta) □ Dual therapy with a LAMA and LABA (e.g., Anoro Ellipta, Bevespi Aerosphere, Stiolto Respimat) and a failure, contraindication, or intolerance to an inhaled corticosteroid (ICS)

United Healthcare Community Plan

Dupixent

PRIOR AUTHORIZATION REQUEST FORM

CHRONIC RHINOSINUSITIS WITH NASAL POLYPOSIS (CRSwNP)	
□ **Yes** □ **No**	**Has the patient had any of the following symptoms for greater than or equal to 12 weeks duration?** *(If yes, check which applies)* □ Nasal mucopurulent discharge □ Nasal obstruction, blockage, or congestion □ Facial pain, pressure, and/or fullness □ Reduction or loss of sense of smell
□ **Yes** □ **No**	**Does the patient have any of the following findings using nasal endoscopy and/or sinus computed tomography (CT)?** *(If yes, check which applies)* □ Purulent mucus or edema in the middle meatus or ethmoid regions □ Polyps in the nasal cavity or the middle meatus □ Radiographic imaging demonstrating mucosal thickening or partial or complete opacification of paranasal sinuses
□ **Yes** □ **No**	**Does the patient have any of the following?** *(If yes, check which applies)* □ Presence of bilateral nasal polyposis □ Previously required surgical removal of bilateral nasal polyps
□ **Yes** □ **No**	**Has the patient required any of the following?** *(If yes, check which applies)* □ Prior sinus surgery □ Systemic corticosteroids (e.g., prednisone, methylprednisolone) for CRSwNP in the previous 2 years
□ **Yes** □ **No**	**Has the patient been unable to obtain symptom relief after a trial of any of the following classes of agents?** *(If yes, check which applies)* □ Nasal saline irrigations □ Intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone) □ Antileukotriene agents (e.g., montelukast, zafirlukast, zileuton)
□ **Yes** □ **No**	**Is the patient currently on Dupixent therapy, as confirmed by submission of medical records?** *(MEDICAL RECORDS MUST BE SUBMITTED)*
□ **Yes** □ **No**	**Will the patient receive Dupixent as add-on maintenance therapy in combination with intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone)?**
CHRONIC RHINOSINUSITIS WITH NASAL POLYPOSIS - REAUTHORIZATION	
□ **Yes** □ **No**	**Is there documentation of positive clinical response to Dupixent therapy?**
□ **Yes** □ **No**	**Will the patient continue to receive Dupixent as add-on maintenance therapy in combination with intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone), as confirmed by submission of medical records?** *(MEDICAL RECORDS MUST BE SUBMITTED)*

United Healthcare Community Plan

Dupixent

PRIOR AUTHORIZATION REQUEST FORM

EOSINOPHILIC ESOPHAGITIS	
□ **Yes** □ **No**	**Is the patient experiencing symptoms related to esophageal dysfunction (e.g., dysphagia, food impaction, chest pain that is often centrally located and may not respond to antacids, gastroesophageal reflux disease-like symptoms/refractory heartburn, upper abdominal pain)?**
□ **Yes** □ **No**	**Will medical records (e.g., chart notes, laboratory values, etc.) be submitted documenting eosinophil-predominant inflammation on esophageal biopsy, consisting of a peak value of 15 or more intraepithelial eosinophils per high power field (HPF) [or 60 eosinophils per mm^2]?** *(MEDICAL RECORDS MUST BE SUBMITTED)*
□ **Yes** □ **No**	**Have secondary causes of esophageal eosinophilia been ruled out?**
□ **Yes** □ **No**	**Is mucosal eosinophilia isolated to the esophagus and symptoms have persisted after an 8-week trial of any of the following, as confirmed by submission of medical records?** *(If yes, check which applies. MEDICAL RECORDS MUST BE SUBMITTED)* □ Proton pump inhibitors (e.g., pantoprazole, omeprazole) □ Topical (esophageal) corticosteroids (e.g., budesonide, fluticasone)
EOSINOPHILIC ESOPHAGITIS - REAUTHORIZATION	
□ **Yes** □ **No**	**Is there documentation of positive clinical response to Dupixent therapy as evidenced by improvement of any of the following from baseline?** *(If yes, check which applies)* □ Symptoms (e.g., dysphagia, chest pain, heartburn) □ Histologic measures (e.g., esophageal intraepithelial eosinophil count) □ Endoscopic measures (e.g., edema, furrows, exudates, rings, strictures)
PRURIGO NODULARIS	
□ **Yes** □ **No**	**Does the patient have greater than or equal to 20 nodular lesions?**
□ **Yes** □ **No**	**Does the patient have <u>failure</u> to at least one previous prurigo nodularis treatment(s) (e.g., topical corticosteroids, topical calcineurin inhibitors, topical capsaicin), as confirmed by submission of medical records?** *(MEDICAL RECORDS MUST BE SUBMITTED)*
□ **Yes** □ **No**	**Does the patient have a history of <u>contraindication or intolerance</u> to all other prurigo nodularis treatment(s) (e.g., topical corticosteroids, topical calcineurin inhibitors, topical capsaicin)?** *(If yes, specify contraindication or intolerance)*
PRURIGO NODULARIS - REAUTHORIZATION	
□ **Yes** □ **No**	**Is there documentation of positive clinical response to Dupixent therapy?**

Physician Signature: _____ **Date:** _____