Dupilumab (Dupixent)

Please fax this completed form to (833) 645-2734 OR mail to: Centene Pharmacy Services | 5 River Park Place East, Suite 210 | Fresno, CA 93720. You can also complete online at CoverMyMeds.com.

Coordinated Care of Washington, Inc. Preferred Drug List: *https://www.coordinatedcarehealth.com/content/dam/centene/centene-pharmacy/pdl/FORMULARY-CoordinatedCare_Washington.pdf*

Date of request:	Reference #:	MAS:	
Patient	Date of birth	ProviderOne ID or Coordinated Care ID	
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
Medication and strength	Directions for use	Qty/Days supply	

1. Indicate patient diagnosis:
   - ☐ Moderate to Severe chronic atopic dermatitis
   - ☐ Oral corticosteroid dependent asthma
   - ☐ Other. Specify:
   - ☐ Asthma with an eosinophilic phenotype
   - ☐ Chronic rhinosinusitis with bilateral nasal polyposis

2. Will this be used in combination with any of the following (check all that apply):
   - ☐ Anti-interleukin 5 therapy (e.g., mepolizumab, resilizumab, benralizumab)
   - ☐ Anti-interleukin 13 therapy (e.g., tralokinumab-ldrm)
   - ☐ Janus kinase inhibitors (e.g., upadacitinib, abrocitinib)

3. Is this prescribed by or in consultation with any of the following (check all that apply):
   - ☐ Allergy/ Immunology
   - ☐ Dermatology
   - ☐ Ear, nose, or throat specialist
   - ☐ Pulmonology
   - ☐ Other. Specify:

4. What is patient's current weight? _____ kg Date taken:

<u>For diagnosis of Atopic Dermatitis, complete the following:</u>

Continuation of therapy for atopic dermatitis:

5. Does patient have clinical documentation of disease stability or improvement defined by any of the following? (Check all that apply)
   - ☐ At least 20% reduction in body surface area (BSA) involvement
   - ☐ Achieved/maintained clear or minimal disease from baseline (equivalent to Investigator's Global Assessment (IGA) score of 0 or 1)
   - ☐ Experienced or maintained a decrease in Eczema Area and Severity Index (EASI) score of at least 50%

6. Does patient have documentation of improvement in functional impairment for any of the following? (Check all that apply)
   - ☐ Improvement in of limitation of activities of daily living (ADLs)
   - ☐ Sleep disturbances
   - ☐ Skin infections
   - ☐ Other. Specify:

New start for atopic dermatitis:

7. Does patient have any of the following? (Check all that apply)
   - ☐ At least 10% body surface area (BSA) involvement

☐ A disease severity scale scoring demonstrating severe chronic atopic dermatitis (e.g., Investigator's Global Assessment (IGA) score of 3 or greater; Eczema Area and Severity Index (EASI), Patient Oriented Eczema Measure (POEM); etc.)
☐ None of the above

8. Does patient have documentation of functional impairment for any of the following? (Check all that apply)
☐ Limitation of activities of daily living (ADLs) ☐ Skin infections
☐ Sleep disturbances ☐ Other. Specify:

9. Indicate if the patient has a history of failure, intolerance, or contraindication to any of the following for a daily treatment minimum of 28 days each (check all that apply):
☐ Topical corticosteroids of at least medium/moderate potency
☐ Topical calcineurin inhibitors (pimecrolimus or tacrolimus)
☐ PDE-4 inhibitors (crisaborole)

For diagnosis of Asthma, complete the following:

Continuation of therapy for asthma with an eosinophilic phenotype or asthma with oral corticosteroid dependent asthma:

10. Is there documentation of disease improvement compared to baseline measures (e.g., reduced missed days from work or school, improved FEV_1, ACQ or ACT scores, decrease in burst of systemic corticosteroids, etc.)?
☐ Yes ☐ No

11. **For asthma with oral corticosteroid dependent asthma:** Has the patient had a reduction in daily oral corticosteroid dosage or usage? ☐ Yes ☐ No

New start for asthma with an eosinophilic phenotype or asthma with oral corticosteroid dependent asthma:

12. Has patient had any of following (check all that apply):
☐ FEV_1 less than (<) 80% predicted
☐ One or more bursts of systemic corticosteroids or oral corticosteroid dependency in the previous 12 months
☐ Frequent (at least twice per year) additional medical treatment such as: emergency department (ED) visits, hospitalizations, treatment with mechanical ventilation, or unplanned (sick) office visits
☐ Limitation of activities of daily living, nighttime awakening, or dyspnea

13. Will patient be using in combination with additional asthma controller medications?
☐ Yes, please indicate the medication and duration of use. _____
☐ No, please explain. _____

14. Does the patient have a history of failure (remains symptomatic after 6 weeks), contraindication or intolerance to any of the following (check all that apply)
☐ High-dose inhaled corticosteroids, in combination with additional controller(s)
☐ Daily oral corticosteroids in combination with high-dose inhaled corticosteroids and additional controller(s)

15. **For diagnosis of asthma with an eosinophilic phenotype:**
What is patient's blood eosinophil count? _____cells/ µL Date taken: _____

For diagnosis of chronic rhinosinusitis with nasal polyposis, complete the following:

16. Will the patient continue to use intranasal corticosteroids with dupilumab? ☐ Yes ☐ No

Continuation of therapy for chronic rhinosinusitis with nasal polyposis:

17. Does patient have clinical documentation of disease improvement compared to baseline defined as a reduction in sinusitis-related symptoms, (such as nasal obstruction, nasal discharge, nasal polyp size, facial pain, and pressure, etc.)? ☐ Yes ☐ No

New start chronic rhinosinusitis with nasal polyposis:

18. Is there clinical documentation in the patient's file confirming the diagnosis of chronic rhinosinusitis with nasal polyposis? ☐ Yes ☐ No

19. Does patient have a history of persistent symptoms of rhinosinusitis after completion of 2 months of intranasal corticosteroid use? ☐ Yes ☐ No

20. Does patient have a history of failure, intolerance, or contraindication to short courses of systemic oral corticosteroids? ☐ Yes ☐ No

CHART NOTES ARE REQUIRED WITH THIS REQUEST		
Prescriber signature	Prescriber specialty	Date

Centene Pharmacy Services will respond via fax or phone within 24 hours of receipt of the request. Requests for prior authorization must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)