OKLAHOMA
Health Care Authority

State of Oklahoma
SoonerCare
Dupixent® (Dupilumab) Prior Authorization Form

Member Name:_____ **Date of Birth:**_____ **Member ID#:**_____

Drug Information

***Pharmacy billing (NDC:**_____**) Fill Date:**_____

***Dose:**_____ ***Regimen:**_____

Billing Provider Information

***Pharmacy NPI:**_____ ***Pharmacy Name:**_____

***Pharmacy Phone:**_____ ***Pharmacy Fax:**_____

Prescriber Information

***Prescriber NPI:**_____ ***Prescriber Name:**_____

***Prescriber Phone:**_____ ***Prescriber Fax:**_____ ***Specialty:**_____

Clinical Information

Page 1 of 2—Please complete and return all pages. Failure to complete all pages will result in processing delays.

For Initial Authorization:

1. Please indicate diagnosis:
   - ❑ Moderate-to-Severe Eosinophilic Phenotype Asthma
   - ❑ Oral Corticosteroid-Dependent Asthma
   - ❑ Moderate-to-Severe Atopic Dermatitis
   - ❑ Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP)
   - ❑ Other, please list: _____

   A. Has the member been counseled on proper administration and storage of Dupixent®?
   Yes____ No____

   B. Has the member been evaluated by an allergist, dermatologist, immunologist, otolaryngologist, pulmonologist, pulmonary specialist within the last 12 months (or an advanced care practitioner with a supervising physician who is one of these specialties)? Yes___ No___
      i. If yes, please include name of specialist: _____ Specialty:_____

   C. Will the member be using Dupixent® concurrently with other biologic medications? Yes____ No____
      i. If yes, please provide patient-specific information to support the concurrent use of both medications:_____

2. If diagnosis is **Moderate-to-Severe Eosinophilic Phenotype Asthma or Oral Corticosteroid-Dependent Asthma**, please provide the following *(Initial approvals will be for the duration of 6 months):*

   A. Will this medication be used as add-on maintenance treatment? Yes___ No___
      i. If yes, please indicate member's daily medications and dose prescribed for treatment of this diagnosis:
      Drug/Dose:_____ Drug/Dose:_____

   B. Baseline blood eosinophil count: _____ Date Determined: _____

   C. Does member require daily systemic corticosteroids despite compliant use of high-dose inhaled corticosteroid (ICS) plus at least one additional controller medication? Yes___ No___
      i. If no, please list number and dates of exacerbations requiring systemic corticosteroids within last 12 months: Number: _____ Dates of exacerbations: _____

   D. Please check all that apply:
      - ❑ Member has failed a high-dose ICS (≥ 880 mcg/day fluticasone propionate or equivalent daily dose or ≥ 440 mcg/day in ages 12 to 17) used compliantly for at least the past 12 months (for ICS/LABA combination products, the highest approved dose meets this criteria)
        - Drug/Dose: _____
      - ❑ Member has failed at least 1 other asthma controller medication used in addition to the high-dose ICS compliantly for at least the past 3 months
        - Drug/Dose: _____

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:
University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit
Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

OKLAHOMA Health Care Authority

State of Oklahoma SoonerCare Dupixent® (Dupilumab) Prior Authorization Form

Member Name:_____ **Date of Birth:**_____ **Member ID#:**_____

Clinical Information

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3. If diagnosis is **Moderate-to-Severe Atopic Dermatitis**, please provide the following *(Initial approvals will be for the duration of 16 weeks)*:
   A. Is member inadequately controlled with topical prescription therapies? Yes____ No____
   B. Has the member failed 1 medium potency to very-high potency Tier-1 topical corticosteroid? Yes____ No____
      i. If yes, please provide the medication and duration of treatment:
         a. Drug:_____ Date of trial:_____
         b. Was the trial at least 2 weeks in duration? Yes____ No____
      ii. If no, is there a contraindication or documented intolerance to medium potency to very-high potency Tier-1 topical corticosteroids? Yes____ No____
         a. If yes, please describe:_____
   C. Has the member failed 1 topical calcineurin inhibitor [e.g., Elidel (pimecrolimus), Protopic (tacrolimus)? Yes____ No____
      i. If yes, please provide the medication and duration of treatment:
         a. Drug:_____ Date of trial:_____
         b. Was the trial at least 2 weeks in duration? Yes____ No____
      ii. If no, is there a contraindication or documented intolerance to topical calcineurin inhibitors? Yes____ No____
         a. If yes, please describe:_____
4. If diagnosis is **Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP)**, please provide the following (*Initial approvals will be for the duration of 6 months)*:
   A. Will Dupixent® be used as add-on maintenance treatment for inadequately controlled CRSwNP? Yes____ No____
   B. Does the member have a trial with intranasal corticosteroid that resulted in failure (or have a contraindication or documented intolerance)? Yes____ No____
      i. If yes, please provide the medication used and dates of use: _____
   C. Has the member required prior sino-nasal surgery? Yes____ No____
   D. Has the member been treated with systemic corticosteroids for CRSwNP in the past 2 years (or have a contraindication or documented intolerance)? Yes____ No____
   E. Does the member have symptoms of chronic rhinosinusitis (e.g., facial pain/pressure, reduction or loss of smell, nasal blockade/obstruction/congestion, nasal discharge) for 12 weeks or longer despite attempts at medical management ? Yes____ No____
   F. Does the member have evidence of nasal polyposis by direct examination, sinus CT scan, or endoscopy? Yes____ No____
   G. Will the member continue to receive intranasal corticosteroid therapy? Yes____ No____
      i. If no, does the member have a contraindication to intranasal corticosteroid therapy? Yes____ No____
         1. If yes, please provide the member's contraindication:_____

For Continued Authorization:

1. Is member compliant with therapy? Yes___ No___
2. Is member responding well to therapy? Yes____ No____

Compliance with all of the prior authorization criteria is a condition for payment for this drug by SoonerCare. All information must be provided and SoonerCare may verify through further requested documentation. The member's drug history will be reviewed prior to approval.

Prescriber Signature:_____ **Date:**_____

By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.)

Please do not send in chart notes. Specific information/documentation will be requested if necessary.

Please complete and return all pages. *Failure to complete all pages will result in processing delays.*

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*