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
   - ❑ Other, please list: _____
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. Has the member been evaluated by an allergist, pulmonologist, or pulmonary specialist within the last 12 months (or an advanced care practitioner with a supervising physician who is an allergist, pulmonologist, or pulmonary specialist)? Yes☐ No☐
     - i. If yes, please include name of specialist: _____
   - E. 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: _____
   - F. Has the member has been counseled on proper administration and storage of Dupixent®?
     Yes☐ No☐

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

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

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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:_____
   D. 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:_____
   E. Has the member been evaluated by an dermatologist, allergist, or immunologist within the last 12 months (or an advanced care practitioner with a supervising physician who is an dermatologist, allergist, or immunologist)? Yes☐ No☐
      i. If yes, please include name of specialist: _____

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 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.*