CVS caremark™ {{PANUMCODE}}

Dupixent

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, **NPI#:** _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

1. What is the diagnosis? *Indicate ALL that apply.*
   - ❑ Moderate-to-severe atopic dermatitis
   - ❑ Moderate-to severe asthma
   - ❑ Chronic rhinosinusitis with nasal polyposis
   - ❑ Other _____

2. What is the ICD-10 code? _____

3. Please indicate the patient's weight (in kilograms): _____

4. What is the dose being prescribed?
   A) Initial dose (i.e., loading dose): _____ mg
   B) Maintenance dose (i.e., continuation of therapy): _____ mg every _____ week(s)

5. Is Dupixent being prescribed by or in consultation with any of the following?
   - ❑ Allergist/Immunologist
   - ❑ Pulmonologist
   - ❑ Otolaryngologist
   - ❑ Dermatologist
   - ❑ Other _____

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Atopic Dermatitis

6. Is the request for continuation of therapy with Dupixent? ❑ Yes ❑ No *If No, skip to #9*

7. Is the patient currently receiving Dupixent through samples or a manufacturer's patient assistance program?
   ❑ Yes ❑ No ❑ Unknown

8. Has the patient achieved or maintained positive clinical response as evidenced by low disease activity (i.e., clear or almost clear skin) or improvement in signs and symptoms of atopic dermatitis (e.g., redness, itching, oozing/crusting) since starting treatment with Dupixent? ***ACTION REQUIRED: If Yes, please attach supporting chart note(s) showing that the patient has experienced a positive clinical response to therapy as evidenced by low disease activity or improvement in signs or symptoms.*** ❑ Yes ❑ No *No further questions*

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

 Dupixent Enhanced SGM - 1/2022.

9. What is the percentage of body surface area (BSA) affected prior to initiation of Dupixent? _____ % of BSA ***ACTION REQUIRED: Please attach supporting chart note(s) or medical record indicating affected areas and body surface area.*** *If greater than or equal to 10% of BSA, skip to #11.*

10. *If less than 10% of BSA is affected,* are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected? ***ACTION REQUIRED: If Yes, please attach supporting chart note(s) or medical record indicating affected area(s).*** ❑ Yes ❑ No

11. Has the patient had an inadequate treatment response to at least TWO medium to super-high potency topical corticosteroids used daily for at least 4 weeks in the past 180 days? ***ACTION REQUIRED: If Yes, please attach supporting chart note(s) or medical record and claims history showing drug names, dosage form, strength, dosage, duration, and response to therapy.*** ❑ Yes ❑ No
    If Yes, indicate the active ingredient, strength, and dosage form of at least TWO medium to super-high potency topical steroids tried by the patient and skip to #13:
    a) _____ b) _____

12. Is the use of topical corticosteroids not advisable for the patient? ***ACTION REQUIRED: If Yes, please attach supporting documentation of why therapy is not advisable.*** ❑ Yes ❑ No

13. Has the patient had an inadequate treatment response to topical tacrolimus (Protopic) used twice daily for at least 6 weeks in the past 180 days? ***ACTION REQUIRED: Please attach patient's chart or medical record and claims history including dosage, duration, and response to therapy.*** *If Yes, no further questions* ❑ Yes ❑ No

14. Is the use of topical tacrolimus (Protopic) not advisable for the patient? ***ACTION REQUIRED: If Yes, please attach supporting documentation of why therapy is not advisable.*** ❑ Yes ❑ No

Section B: Asthma

15. Is this request for continuation of therapy with Dupixent? ❑ Yes ❑ No *If No, skip to #22*

16. Is the patient currently receiving Dupixent through samples or a manufacturer's patient assistance program? *If unknown, answer Yes and skip to #22* ❑ Yes ❑ No

17. Has the patient achieved and maintained positive clinical response with Dupixent therapy for asthma as evidenced by at least one of the following? ***ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of positive clinical response.***
    ❑ A reduction in the frequency and/or severity of symptoms and exacerbations
    ❑ A reduction in the daily maintenance oral corticosteroid dose
    ❑ None of the above

18. Will the patient receive Dupixent as monotherapy (i.e., without any other asthma medications such as inhaled corticosteroids)? ❑ Yes ❑ No

19. Will the patient receive Dupixent concomitantly with other biologics indicated for asthma (e.g., Cinqair, Fasenra, Nucala or Xolair)? ❑ Yes ❑ No

20. Does the patient have co-morbid moderate-to-severe atopic dermatitis?
    ❑ Yes ❑ No *No further questions*

22. Prior to Dupixent therapy, what was the patient's baseline (e.g., before significant oral steroid use) blood eosinophil count in cells per microliter? ***ACTION REQUIRED: Please attach supporting chart note(s) or medical record with the patient's baseline blood eosinophil count.*** _____ cells per microliter
    ❑ Unknown *If less than 150 cells per microliter or Unknown, skip to #24*

23. Prior to receiving Dupixent, did the patient have inadequate asthma control (e.g. hospitalization or emergency medical care visit within the past year) despite concomitant treatment with all of the following medications at optimized doses? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history of previous medications tried including drug, dose, frequency, and duration and skip to #26.***
    ❑ Yes ❑ No *List continues on next page.*
    a) High-dose inhaled corticosteroid

a1) Adult and adolescent members (12 years age and older): greater than 500 microgram total daily dose of fluticasone propionate or equivalent
a2) Pediatric members (6 to 11 years of age): greater than 200 microgram total daily dose of fluticasone propionate or equivalent
b) Additional controller (long acting beta$_2$-agonist, leukotriene modifier, or sustained-release theophylline)
c) Oral glucocorticoids (at least 5 mg per day of prednisone/prednisolone or equivalent)

24. Has the patient received treatment with the inhaled corticosteroid and additional controller for at least 3 months? ❑ Yes ❑ No

25. Has the patient received treatment with oral glucocorticoids for most days during the previous 6 months (e.g. 50% of days, 3 steroid bursts in the previous 6 months)? ❑ Yes ❑ No

26. Will the patient receive Dupixent as monotherapy (i.e., without any other asthma medications such as inhaled corticosteroids)? ❑ Yes ❑ No

27. Will the patient receive Dupixent concomitantly with other biologics indicated for asthma (e.g., Cinqair, Fasenra, Nucala or Xolair)? ❑ Yes ❑ No

Section C: Chronic Rhinosinusitis with Nasal Polyposis

28. Is the request for continuation of therapy with Dupixent? ❑ Yes ❑ No *If No, skip to #31*

29. Is the patient currently receiving Dupixent through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip #31* ❑ Yes ❑ No ❑ Unknown

30. Has the patient achieved or maintained positive clinical response as evidenced by improvement in signs and symptoms of CRSwNP (e.g., improvement in nasal congestion, nasal polyp size, loss of smell, anterior or posterior rhinorrhea, sinonasal inflammation, hyposmia and/or facial pressure or pain or reduction in corticosteroid use)? ***ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of positive clinical response.*** ❑ Yes ❑ No *No further questions*

31. Does the patient have bilateral nasal polyposis and chronic symptoms of sinusitis? ❑ Yes ❑ No

32. Has the patient had intranasal corticosteroid treatment for at least 2 months? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history of previous medications tried and skip to #34.*** ❑ Yes ❑ No

33. Are intranasal corticosteroids contraindicated or not tolerated? ***ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy.*** ❑ Yes ❑ No

34. Has the patient had prior sino-nasal surgery? *If Yes, skip to #37* ❑ Yes ❑ No

35. Has the patient had an inadequate response with systemic corticosteroids within the last two years? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history of previous medications tried and skip to #37.*** ❑ Yes ❑ No

36. Are systemic corticosteroids contraindicated or not tolerated? ***ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy.*** ❑ Yes ❑ No

37. Has the patient had a bilateral nasal endoscopy or anterior rhinoscopy showing polyps reaching below the lower border of the middle turbinate or beyond in each nostril? ***ACTION REQUIRED: If Yes, please attach supporting chart note(s) or medical record showing endoscopy or rhinoscopy details (e.g., polyps location, size).*** ❑ Yes ❑ No

38. Does the patient have nasal blockage? ❑ Yes ❑ No

39. Does the patient have rhinorrhea (anterior/posterior) or reduction or loss of smell? ❑ Yes ❑ No

40. Will the patient be using a daily intranasal corticosteroid while being treated with Dupixent? *If Yes, no further questions* ❑ Yes ❑ No

41. Are intranasal corticosteroids contraindicated or not tolerated? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155