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.

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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 prescribed dose and frequency?
   a) Loading dose:
   ❑ Dupixent 100 mg Quantity and Frequency: _____
   ❑ Dupixent 200 mg Quantity and Frequency: _____
   ❑ Dupixent 300 mg Quantity and Frequency: _____
   ❑ Other: _____
   b) Maintenance dose:
   ❑ Dupixent 100 mg Quantity and Frequency: _____
   ❑ Dupixent 200 mg Quantity and Frequency: _____
   ❑ Dupixent 300 mg Quantity and Frequency: _____
   ❑ Other: _____

2. What is the diagnosis?
   ❑ Atopic dermatitis, moderate-to-severe ❑ Asthma
   ❑ Chronic rhinosinusitis with nasal polyposis ❑ Other _____

3. What is the ICD-10 code? _____

4. What is the patient's weight? _____ kg or lbs ***(Circle one)***

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

Section A: Atopic Dermatitis

5. Is the request for continuation of therapy with Dupixent? ❑ Yes ❑ No *If No, skip to #8*

6. Is the patient currently receiving Dupixent through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to #8* ❑ Yes ❑ No ❑ Unknown

7. 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? ❑ Yes ❑ No *No further questions.*

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8. What is the percentage of body surface area (BSA) affected prior to initiation of Dupixent? _____%
   If greater than or equal to 10% of BSA, skip to #10

9. Are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected?
   ❑ Yes ❑ No

10. To which topical therapies, if any, has the patient had an inadequate treatment response in the past 180 days?
    ACTION REQUIRED: Please attach supporting chart note(s) or medical record showing prerequisite therapies including drug name, dosage form and strength. *List continues on next page.*
    ❑ Topical corticosteroid
    ❑ Topical calcineurin inhibitor, *no further questions*
    ❑ Both a topical corticosteroid and a topical calcineurin inhibitor, *no further questions*
    ❑ None of the above, *skip to #12*

11. What is the potency of the highest-potency topical corticosteroid the patient has tried in the past 180 days?
    If high potency or super-high potency topical steroid was tried, please indicate the active ingredient, strength, and dosage form of the high potency or super-high potency topical steroid that was tried and no further questions.
    ❑ Least potent
    ❑ Low potency
    ❑ Lower-mid potency
    ❑ Medium potency
    ❑ High potency - *active ingredient, strength, and dosage form*: _____
    ❑ Super high potency - *active ingredient, strength, and dosage form*: _____

12. Is the use of high-potency or super-high potency topical corticosteroids and topical calcineurin inhibitors not advisable for the patient (e.g., due to contraindications or prior intolerances)? ❑ Yes ❑ No

Section B: Asthma

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

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

15. Is the request for continuation of therapy with Dupixent? ❑ Yes ❑ No *If No, skip to #21*

16. Is the patient currently receiving Dupixent through samples or a manufacturer's patient assistance program?
    If Yes or Unknown, skip to #18 ❑ Yes ❑ No ❑ Unknown

17. Has asthma control improved on Dupixent treatment, as demonstrated by at least one of the following?
    ACTION REQUIRED: If Yes, please attach supporting chart notes or medical record documentation of improved asthma control. *Indicate below and no further questions*
    ❑ 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. 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 #21*

19. Prior to receiving Dupixent, did the patient have inadequate asthma control (e.g. hospitalization or emergency medical care visit within the past year) despite current treatment with both of the following medications at optimized doses? ***ACTION REQUIRED: If Yes, please attach supporting chart notes, medical records, or claims history of previous medications tried including drug, dose, frequency, and duration.***
    ❑ Yes ❑ No *No further questions.*
    A) Inhaled corticosteroid
    B) Additional controller (long acting beta$_2$-agonist, leukotriene modifier, or sustained-release theophylline)

20. 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 supporting chart notes, medical records, or claims history of previous medications tried including drug, dose, frequency, and duration and skip to #24.*** ❑ Yes ❑ No
    A) High-dose inhaled corticosteroid
    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)

21. What is 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 #23*

22. Does the patient have inadequate asthma control (e.g. hospitalization or emergency medical care visit within the past year) despite current treatment with both of the following medications at optimized doses:
    ❑ Yes ❑ No *No further questions.*
    A) Inhaled corticosteroid
    B) Additional controller (long acting beta$_2$-agonist, leukotriene modifier, or sustained-release theophylline)

23. Does 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 supporting chart note(s) or medical record showing patient's oral glucocorticoid use history, including drug, dose, frequency and duration.*** ❑ Yes ❑ No
    A) High-dose inhaled corticosteroid
    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 the previous 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

Section C: Chronic Rhinosinusitis with Nasal Polyposis

26. Is the request for continuation of therapy with Dupixent? ❑ Yes ❑ No *If No, skip to #29*

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

28. 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 supporting chart notes or medical record documentation of positive clinical response.*** ❑ Yes ❑ No *No further questions.*

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

30. Has the patient had intranasal corticosteroid treatment for at least 2 months? ***ACTION REQUIRED: If Yes, please attach supporting chart notes, medical records, or claims history of previous medications tried.*** ❑ Yes ❑ No

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

32. Has the patient had prior sino-nasal surgery? *If Yes, skip to #35* ❑ Yes ❑ No

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

34. Are systemic corticosteroids contraindicated or not tolerated? ***ACTION REQUIRED: If Yes, please attach supporting chart notes, medical records, or claims history of previous medications tried.*** ❑ Yes ❑ No
35. 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
36. Does the patient have nasal blockage? ❑ Yes ❑ No
37. Does the patient have rhinorrhea (anterior/posterior) or reduction or loss of smell? ❑ Yes ❑ No
38. Will the patient be using a daily intranasal corticosteroid while being treated with Dupixent? *If Yes, no further questions* ❑ Yes ❑ No
39. 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)**

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