HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM
DUPIXENT®

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 888-509-8142. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Dupixent® (dupilumab)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
ATOPIC DERMATITIS			
1. Does the member have a diagnosis of moderate to severe atopic dermatitis?	☐	☐	**Please provide documentation**
2. Is the requesting provider a dermatologist, allergist, pulmonologist, or in consultation with one of these specialists?	☐	☐	
3. Has the member had a trial and failure with at least 2 moderate to very high potency prescription corticosteroids?	☐	☐	**Please provide documentation**
4. If unable to tolerate corticosteroids due to the treatment area (e.g. face, genitals, etc.), has the member had a trial and failure to a calcineurin inhibitor, such as topical tacrolimus, unless contraindicated?	☐	☐	**Please provide documentation**
5. Has the member tried phototherapy?	☐	☐	**Please provide documentation**
6. Has the member had a trial and failure of at least one of the following in the past 6 months: • Oral corticosteroid • Intramuscular steroid • cyclosporine • azathioprine • methotrexate • mycophenolate	☐	☐	**Please provide documentation**

ASTHMA			
1. Does the member have a diagnosis of moderate to severe asthma?	☐	☐	**Please provide documentation**
2. Is the member being followed by an allergist, pulmonologist or immunologist?	☐	☐	
3. Is the member 12 years of age or older?	☐	☐	
4. Has the member had a trial and failure of Fasenra™, unless contraindicated?	☐	☐	**Please provide documentation**
5. Has the member shown to be ≥80% compliant for at least 5 months with high dose inhaled corticosteroids AND long acting inhaled beta-2 agonists?	☐	☐	**Please provide documentation**
6. Does the member have poor asthma control with recurrent exacerbations that have requiredemergency department visits, hospitalizations, office visits, and a Current Asthma Control Test (ACT) score ≤19?	☐	☐	**Please provide documentation**
7. Does documentation show the member's baseline FEV1?	☐	☐	**Please provide documentation**
8. Are underlying conditions or triggers for asthma or pulmonary disease being maximally managed (i.e. inhaled respiratory irritants – tobacco, allergen exposure, physical activity, medications, emotional factors, respiratory infections, COPD, etc.)?	☐	☐	**Please provide documentation**
9. Does the member have a baseline eosinophil count >300 cells/µL in the last 6 weeks?	☐	☐	**Please provide documentation**
CHRONIC RHINOSINUSITIS			
1. Does the member have a diagnosis of chronic rhinosinusitis with nasal polyposis noted on current exam?	☐	☐	**Please provide documentation**
2. Is the requesting provider an allergist, pulmonologist, ENT specialist or in consultation with one?	☐	☐	
3. Has the member had a trial and failure of the following: • Two preferred nasal corticosteroids (ie: fluticasone propionate nasal spray, mometasone nasal spray) • Xhance®	☐	☐	**Please provide documentation**
4. Has the member tried and failed at least two weeks of systemic corticosteroid therapy?	☐	☐	**Please provide documentation**
5. Has the member tried and failed at least two weeks of doxycycline or macrolide antibiotics?	☐	☐	**Please provide documentation**
6. Will Dupixent® be used in combination with an intranasal corticosteroid?	☐	☐	
REAUTHORIZATION			
ATOPIC DERMATITIS			
1. Is the request for reauthorization of atopic dermatitis therapy?	☐	☐	
2. Is there evidence of positive clinical response?	☐	☐	**Please provide documentation**
ASTHMA			
1. Is the request for reauthorization for asthma therapy?	☐	☐	

2. Is there evidence of positive clinical response as defined by documentation demonstrating reduced hospitalization and/or emergency room visits?	☐	☐	**Please provide documentation**
CHRONIC RHINOSINUSITIS			
1. Is the request for reauthorization of chronic rhinosinusitis therapy?	☐	☐	
2. Has the member experienced a reduction in their nasal polyp size and nasal congestion?	☐	☐	

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:

Physician Signature:

****Failure to submit clinical documentation to support this request will result in delay and/or denial of the request****

Policy PHARM-022
Origination Date: 07/12/2017
Reviewed/Revised Date: 10/28/2020
Next Review Date: 10/28/2021
Current Effective Date: 11/01/2020