MOLINA HEALTHCARE
Service Authorization (SA) Form
DUPIXENT®

If the following information is not complete, correct, or legible, the SA process can be delayed.

Please use one form per member.

Dupixent for atopic dermatitis has an electronic edit and does not require submission of this fax form; this form is for other indications. Length of Authorization = 1 year.

MEMBER INFORMATION

Last Name:

First Name:

Medicaid ID Number:

Date of Birth: ___ – ___ – ____

Expected Pregnancy Term Date: ___ – ___ – ____

Requested Start Date: ___ – ___ – ____

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name:

First Name:

NPI Number:

Phone Number: ___ – ___ – ____

Fax Number: ___ – ___ – ____

DIAGNOSIS AND MEDICAL INFORMATION

For a diagnosis of chronic rhinosinusitis with nasal polyps only:

1. Is the member 12 years of age or older?
   ☐ Yes ☐ No
2. Does the member have inadequate response after 3 consistent months of use of preferred intranasal steroids or oral corticosteroids?
   ☐ Yes ☐ No
3. Is the member concurrently being treated with intranasal corticosteroids?
   ☐ Yes ☐ No
4. Has the physician assessed baseline disease severity utilizing an objective measurement/tool?
   ☐ Yes ☐ No

(Form continued on next page)

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Molina SA Form: Dupixent®

Member's Last Name:

Member's First Name:

For a diagnosis of moderate to severe asthma:

1. Is the member 6 years of age or older?
   ☐ Yes ☐ No
2. Does the member have a diagnosis of moderate to severe asthma with either:
   - Asthma with eosinophilic phenotype with eosinophil count ≥ 150 cells/mcL; **OR**
   - Oral corticosteroid-dependent asthma with at least 1 month of daily oral corticosteroid use within the last 3 months

   ☐ Yes ☐ No

For a diagnosis of eosinophilic esophagitis (EoE):

1. Is the member 1 years of age or older?
   ☐ Yes ☐ No
2. Does the member weigh ≥ 15 kg?
   ☐ Yes ☐ No
3. Is Dupixent prescribed by or in consultation with an allergist or gastroenterologist?
   ☐ Yes ☐ No
4. Has the member responded clinically to treatment with a topical glucocorticosteroid or proton pump inhibitor?
   ☐ **Yes** ☐ **No**

For adult members with inadequately controlled chronic obstructive pulmonary disease (COPD) and an eosinophilic phenotype:

1. Is the member 18 years of age or older?
   ☐ Yes ☐ No
2. Is Dupixent prescribed by or in consultation with a pulmonologist? ☐ Yes ☐ No
3. Does the member have a diagnosis of COPD that is inadequately controlled and a minimum blood eosinophil count of 300 cells/mcL at screening, measured within the past 12 months?
   ☐ Yes ☐ No
4. Is the member receiving maximal inhaled therapy defined as the following:
   - Therapy with long-acting muscarinic antagonist (LAMA), long-acting beta-agonist (LABA), and inhaled corticosteroid (ICS)
     OR
   - Therapy with long-acting muscarinic antagonist (LAMA) and long-acting beta-agonist (LABA) if inhaled corticosteroid (ICS) is contraindicated

   ☐ Yes ☐ No

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5. Does the member have one of the following in the past 12 months with one exacerbation occurring while the patient was on maximal inhaled therapy?
    - At least TWO moderate exacerbations requiring treatment with systemic corticosteroids and/or antibiotics
      OR
    - At least ONE severe exacerbation(s) resulting in hospitalization or observation for over 24 hours in an emergency department or urgent care facility

For adult members with a diagnosis of prurigo nodularis (PN):

1. Is the member 18 years of age or older?
   ☐ Yes ☐ No
2. Does the member have a diagnosis of PN?
   ☐ Yes ☐ No
3. Is Dupixent prescribed by or in consultation with a dermatologist, allergist, or immunologist?
   ☐ Yes ☐ No

For renewal:

1. Has the member experienced a therapeutic benefit from the requested medication?
   ☐ Yes ☐ No
1. Is the member free of toxicity from the requested medication?
   ☐ Yes ☐ No

Prescriber Signature (Required) By signature, the Physician confirms the above information is accurate and verifiable by member records.	**Date**

Please include ALL requested information; incomplete forms will delay the SA process.

Submission of documentation does NOT guarantee coverage by Molina Healthcare.

The completed form may be: **FAXED** to **(844) 278-5731**, or you may call **(800) 424-4518** (TTY: 711).

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