MOLINA HEALTHCARE

Iowa Health Link Iowa HHS Hawki Iowa HHS

Request for Prior Authorization
Dupilumab (Dupixent)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

FAX Completed Form To
1 (877) 733-3195

Provider Help Desk
1 (844) 236-1464

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for Dupixent (dupilumab). Payment for non-preferred agents will be considered when there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered when patient has an FDA approved or compendia indication for the requested drug under the following conditions:

1) Request adheres to all FDA approved labeling for requested drug and indication including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
2) Patient's current weight in kilograms (kg) is provided; and
3) Patient has a diagnosis of moderate-to-severe atopic dermatitis; and
   a. Patient has failed to respond to good skin care and regular use of emollients; and
   b. Patient has documentation of an adequate trial and therapy failure with one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; and
   c. Patient has documentation of a previous trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and
   d. Patient will continue with skin care regimen and regular use of emollients; or
4) Patient has a diagnosis of moderate to severe asthma with an eosinophilic phenotype (with a pretreatment eosinophil count ≥ 150 cells/mcL within the previous 6 weeks) OR with oral corticosteroid dependent asthma; and
   a. Has a pretreatment forced expiratory volume in 1 second (FEV_1) ≤ 80% predicted in adults; < 90% predicted in adolescents 12 to 17 years of age; and < 95% predicted in children 6 to 11 years of age; and
   b. Symptoms are inadequately controlled with documentation of current treatment with a high-dose inhaled corticosteroid (ICS) given in combination with a controller medication (e.g. long acting beta2 agonist [LABA], leukotriene receptor antagonist [LTRA], oral theophylline) for a minimum of 3 consecutive months. Patient must be compliant with therapy, based on pharmacy claims; and
   c. Patient must have one of the following, in addition to the regular maintenance medications defined above:
      i. One (1) or more exacerbations in the previous year, or
      ii. Require daily oral corticosteroids for at least 3 days; or
5) Patient has a diagnosis of inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP); and
   a. Documentation dupilumab will be used as an add-on maintenance treatment; and
   b. Documentation of an adequate trial and therapy failure with at least one preferred medication from each of the following categories:
      i. Nasal corticosteroid spray; and
      ii. Oral corticosteroid; or
6) Patient has a diagnosis of eosinophilic esophagitis (EoE); and
   a. Patient has ≥ 15 intraepithelial eosinophils per high-power field (eos/hpf) as confirmed by endoscopic esophageal biopsy (attach results); and
   b. Patient has signs and symptoms of esophageal dysfunction (e.g., dysphagia, food impaction, food refusal, abdominal pain, heartburn regurgitation, chest pain and/or, odynophagia); and
   c. Documentation of previous trials and therapy failures with all of the following:
      i. High dose proton pump inhibitor (PPI) for at least 8 weeks; and
      ii. Swallowed topical corticosteroid (e.g., fluticasone propionate, oral budesonide suspension); and
      iii. Dietary therapy; or

7) Patient has a diagnosis of moderate to severe prurigo nodularis (PN); and
   a. Patient has experienced severe to very severe pruritis, as demonstrated by a current Worst Itch-Numeric Rating Scale (WI-NRS) ≥ 7; and
   b. Patient has ≥ 20 nodular lesions (attach documentation); and
   c. Documentation of a previous trial and therapy failure with a high or super high potency topical corticosteroid for at least 14 consecutive days; or
8) Patient has a diagnosis of chronic obstructive pulmonary disease (COPD) and an eosinophilic phenotype; and
   a. Patient has moderate to severe airflow limitation, measured within the past 12 months, as evidenced by both of the following:
      i. FEV1/FVC ratio < 0.7, and
      ii. FEV1 % predicted between 30% to79%; and
   b. Patient has a minimum blood eosinophil count of 300 cells/mcL, measured within the past 12 months; and
   c. Patient has documentation of maximal inhaled therapy for 3 or more months and an inadequate response to:
      i. Triple therapy with all of the following treatments:
         1. Long-acting muscarinic antagonist/anticholinergic (LAMA); and
         2. Long-acting beta agonist (LABA); and
         3. Inhaled corticosteroid (ICS); or
      ii. Double therapy with all of the following if ICS is contraindicated
         1. LABA; and
         2. LAMA; and
   d. Patient has history of at least 2 moderate or 1 severe exacerbation(s) in the previous 12 months despite receiving maximal triple therapy or double therapy (defined above). Moderate exacerbation is defined as patient required treatment with systemic corticosteroids and/or antibiotics and severe exacerbation is defined as hospitalization or observation for over 24 hours in an emergency department or urgent care facility; and
   e. Patient will continue to receive maintenance therapy (as documented above) concomitantly with dupilumab; and
9) Dose does not exceed the FDA approved dosing for indication.

If criteria for coverage are met, initial authorizations will be given for 6 months for all the above indications, except COPD, which will receive an initial authorization of 12 months to assess the response to treatment. Requests for continuation of therapy will require documentation of a positive response to therapy.

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Preferred

☐ Dupixent

Strength	Usage Instructions	Quantity	Day's Supply
_____	_____	_____	_____

Diagnosis:_____

Patient's current weight in kg:_____ Date obtained: _____

☐ **Moderate-to-Severe Atopic Dermatitis**

Did patient fail to respond to good skin care and regular use of emollients?

☐ Yes ☐ No If yes, provide documentation below:

Provide skin care regimen, including name and dates of emollient use:_____

_____

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Will patient continue skin care regimen and regular use of emollients? □ Yes □ No

Preferred medium to high potency topical corticosteroid trial:

Drug name & dose:_____ Trial dates:_____

Failure reason:_____

Topical immunomodulator trial:

Drug name & dose:_____ Trial dates:_____

Failure reason:_____

☐ **Moderate-to-Severe Asthma with an Eosinophilic Phenotype**

Does patient have pretreatment eosinophil count ≥ 150 cells/mcL within the previous 6 weeks?
☐ Yes (attach results) ☐ No

Does patient have oral corticosteroid dependent asthma?
☐ Yes ☐ No

Provide pretreatment FEV_1 % predicted (attach results): _____

Document current treatment with a high-dose ICS given in combination with a controller medication: High-Dose ICS Trial:

Drug name & dose:_____ Trial dates:_____

Failure reason:_____

Controller Medication Trial:

Drug name & dose:_____ Trial dates:_____

Failure reason:_____

Does patient have one of the following?

One (1) or more exacerbations in the previous year? ☐ Yes ☐ No

Require daily oral corticosteroids for at least 3 days? ☐ Yes ☐ No

☐ **Inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP)**

Will dupliumab be used as an add-on maintenance treatment?

☐ Yes (document concomitant maintenance treatment): Drug name &dose: _____

☐ No

Document adequate trial and therapy failure with at least one preferred medication from each of the following categories:

Nasal Corticosteroid Spray Trial:

Drug name & dose:_____ Trial dates:_____

Failure reason:_____

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Oral Corticosteroid Trial:

Drug name & dose:_____ Trial dates:_____

Failure reason:_____

☐ **Eosinophilic Esophagitis (EoE)**

Does patient have ≥ 15 intraepithelial eosinophils per high-power field (eos/hpf) confirmed by endoscopic esophageal biopsy?

☐ Yes (attach results) ☐ No

Does patient have signs and symptoms of esophageal dysfunction?

☐ Yes; provide signs and symptoms: _____

☐ No

Document previous trials and therapy failures with all of the following:

High Dose PPI:

Drug name & dose:_____ Trial dates:_____

Failure reason:_____

Swallowed topical corticosteroid:

Drug name & dose:_____ Trial dates:_____

Failure reason:_____

Dietary Therapy:

Dietary Plan:_____ Trial dates:_____

Failure reason:_____

☐ **Moderate to Severe Prurigo Nodularis (PN)**

Worst Itch-Numeric Rating Scale (WI-NRS) response: _____ Date obtained: _____

Does patient have > 20 nodular lesions? ☐ Yes (provide documentation) ☐ No

Preferred high or super high potency topical corticosteroid trial:

Drug name & dose:_____ Trial dates:_____

Failure reason:_____

☐ **Chronic Obstructive Pulmonary Disease (COPD) and an eosinophilic phenotype:**

Provide all of the following information:

FEV1/FVC ratio: _____ Date obtained: _____

FEV1 % predicted: _____ Date obtained: _____

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Blood eosinophil count: _____ Date obtained: _____

Trial information:

LABA Trial:

Name/dose:_____ Trial dates:_____

Failure reason/medical contraindication: _____

LAMA Trial:

Name/dose:_____ Trial dates:_____

Failure reason/medical contraindication: _____

ICS Trial:

Name/dose:_____ Trial dates:_____

Failure reason/medical contraindication: _____

_____

Document exacerbations:

Moderate:

Date: _____ **Treatment needed:** _____

Date: _____ **Treatment needed:** _____

Severe:

Date: _____ **Place of care:** _____

Will patient continue to receive maintenance therapy concomitantly with dupilumab? □ Yes □ No

Renewal requests:

Document positive response to therapy:_____

_____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.*