PRIOR AUTHORIZATION FORM
Dupixent - Commercial/Medicaid

Unless otherwise indicated below, authorization quantities are limited to the manufacturer recommended dosage

SCRIPUS
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P.O. Box 30192 Salt Lake City, UT 84130

Complete online at www.selecthealth.org/pa or fax back to: 801-650-3279 **For questions or clarifications, call: 800-442-3129**	
Patient Information	
Patient's Name:	Patient's Date of Birth:
Patient's ID:	Patient's Phone #:
Diagnosis Code(s):	
Requesting Provider Information	
Name:	Phone #:
NPI/DEA:	Fax #:
Address:	Supervising Physician (if requesting provider bills under a different provider)
	Name:
	NPI/DEA:
Servicing Provider Information (if different than requesting provider)	
Name of provider or facility:	Phone number:
NPI/DEA:	Address:

Drug Name and Strength:	Directions / SIG:

Q1. Is this a reauthorization request?

☐ Yes ☐ No

Q2. What is the patient's diagnosis?

☐ Moderate-to-severe atopic dermatitis
☐ Moderate-to-severe asthma with an eosinophilic phenotype
☐ Oral corticosteroid dependent asthma
☐ Chronic rhinosinusitis with nasal polyposis
☐ Eosinophilic esophagitis (EoE)
☐ Prurigo nodularis (PN)
☐ Other

Q3. If other, please specify:

Q4. Does the patient's treatment plan include concurrent therapy with another biologic medication (e.g. Xolair, Xeljanz, Otezla, Entyvio)?

☐ Yes ☐ No

Q5. For asthma diagnoses, has the patient smoked within the last 3 months?

☐ Yes ☐ No

Q6. For eosinophilic esophagitis, does the patient meet any of the following?

☐ Less than 12 years of age
☐ Body weight of 40kg or less
☐ Diagnosed with hyper eosiniphilic syndrome (HES) and eosinophilic granulomatosis with polyangiitis (Churg-Strauss syndrome)
☐ Active Helicobacter pylori infection (H. pylori)
☐ History of achalasia, Crohn's disease, ulcerative colitis, celiac disease, and prior esophageal surgery
☐ Any esophageal stricture unable to be passed via standard endoscope
☐ History of bleeding disorder or esophageal varices
☐ None of the above

Q7. For prurigo nodularis, is the patient diagnosed with PN with any of the following?

☐ Pemphigoid nodularis (bullous pemphigoid)
☐ Actinic prurigo
☐ Epidermolysis bullosa
☐ Hypertrophic lichen planus
☐ Neurotic/psychiatric excoriations (dermatotillomania)
☐ None of the above

Q8. Is the patient's PN secondary to medications (i.e., pembrolizumab, paclitaxel, and carboplatin), uncontrolled thyroid disease, immunodeficiency, endoparasitic infection, active infection (except HIV infection) requiring systemic antibiotics, antivirals, antiprotozoal, or antifungals within last two weeks?

☐ Yes ☐ No

Q9. For moderate-to-severe AD, does the patient have atopic dermatitis affecting 10 percent or more of body surface area (BSA) coverage?

☐ Yes ☐ No

Q10. Has the patient failed treatment with at least TWO of the following treatments? Please check all that apply:

☐ Topical corticosteroid
☐ Topical calcineruin inhibitor
☐ Phototherapy
☐ Oral immunomodulator
☐ Eucrisa
☐ None of the above

Q11. Is the patient 6 months of age or older?

☐ Yes ☐ No

Q12. For reauthorization for atopic dermatitis, has the patient experienced a significant decrease in itching and improvement in BSA?

☐ Yes ☐ No

Q13. For moderate to severe asthma with eosinophilic phenotype, is the patient's peripheral blood eosinophil level greater than 150 cells/mcL?

☐ Yes ☐ No

Q14. Is the patient 6 years of age or older?

☐ Yes ☐ No

Q15. For chronic oral corticosteroid dependent asthma, has the patient required chronic oral corticosteroid therapy for at least the last 3 months?

☐ Yes ☐ No

Q16. Does the patient have a history of one or more exacerbations requiring the use of oral corticosteroids in the previous 12 months?

☐ Yes ☐ No

Q17. For reauthorization for chronic oral corticosteroid dependent asthma, has the patient had greater than or equal to 50 percent reduction in chronic daily corticosteroid therapy?

☐ Yes ☐ No

Q18. For moderate to severe asthma with eosinophilic phenotype or chronic oral corticosteroid dependent asthma, has the patient previous used an inhaled corticosteroid?

☐ Yes ☐ No

Q19. Has the patient previously used an inhaled corticosteroid/long-acting beta-agonist (ICS/LABA), long-acting muscarinic antagonist (LAMA) (Spiriva), ICS/LABA/LAMA (Trelegy), or a leukotriene receptor antagonist (LTRA)?

☐ Yes ☐ No

Q20. For chronic rhino-sinusitis with nasal polyps, has the patient been compliant with and failed at least two months of intranasal corticosteroid therapy and saline irrigation?

☐ Yes ☐ No

Q21. Has the patient failed at least two weeks of systemic corticosteroid therapy?

☐ Yes ☐ No

Q22. Will Dupixent be used in combination with intranasal corticosteroid therapy?

☐ Yes ☐ No

Q23. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q24. For reauthorization for chronic rhino-sinusitis with nasal polyps, has the patient experienced a reduction in their nasal polyp size and nasal congestion?

☐ Yes ☐ No

Q25. For EoE, does the patient have a documented diagnosis confirmed by endoscopic biopsy with greater than or equal to 15 intraepithelial eosinophils per high-power field (eos/hpf)?

☐ Yes ☐ No

Q26. Has the patient had failure of at least 8 weeks high-dose PPI?

☐ Yes ☐ No

Q27. Has the patient had failure of swallowed topical corticosteroid (i.e. fluticasone propionate, oral budesonide suspension)?

☐ Yes ☐ No

Q28. For prurigo nodularis, does the patient have a worst-itch numeric rating scale score (WiNRS) greater than or equal to 7?

☐ Yes ☐ No

Q29. Does the patient have a minimum of 20 PN lesions?

☐ Yes ☐ No

Q30. Has the patient failed two weeks medium potency TCS and one of the following?

☐ Topical capsaicin
☐ Topical calcineurin inhibitors
☐ Topical vitamin D analogs
☐ Phototherapy
☐ Systemic immunosuppressants (i.e., methotrexate or cyclosporine) OR thalidomide/lenalidomide
☐ None of the above

Q31. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q32. Additional comments:

This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-650-3279. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.

_____ _____

Prescriber Signature Date