BlueCross BlueShield Federal Employee Program

DUPIXENT
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		

PHYSICIAN COMPLETES

All approved requests are subject to review by a clinical specialist for final validation and coverage determination once all required documentation has been received. Current utilization, including samples, does not guarantee approval of coverage.

Dupixent (dupilumab)

NOTE: Form must be completed in its **entirety** for processing

Please select strength: ❑**100mg** ❑**200mg** ❑**300mg**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

Is this request for brand or generic? ❑Brand ❑Generic

1. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No
2. What is the patient's diagnosis?

❑Asthma OR ❑Asthma AND chronic obstructive pulmonary disease (COPD)

a. Will this medication be used for the emergency relief of acute bronchospasm or status asthmaticus? ❑Yes ❑No

b. Will this medication be used in combination with another monoclonal antibody for the treatment of asthma or COPD? ❑Yes* ❑No

If YES, please specify medication: _____

c. Has the patient been on this medication continuously for the last **3 months** excluding samples? ***Please select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

i. Is the patient's asthma moderate-to-severe? ❑Yes ❑No

ii. Does the patient have a diagnosis of asthma with an eosinophilic phenotype? ❑Yes ❑No

iii. Does the patient have an eosinophil count greater than or equal to 150 cells/mcL in the past 90 days? ❑Yes ❑No*

If NO, does the patient have an eosinophil count greater than or equal to 300 cells/mcL in the past 12 months? ❑Yes ❑No

iv. Does the patient have oral corticosteroid dependent asthma? ❑Yes ❑No

v. Has the patient had at least 1 month of daily oral corticosteroid use within the last 3 months? ❑Yes ❑No*

If NO, does the patient currently require oral corticosteroids? ❑Yes ❑No

vi. Has the patient had 2 or more moderate asthma exacerbations in the past year? ❑Yes ❑No*

If NO, has the patient had 1 or more severe asthma exacerbations leading to hospitalization in the past year? ❑Yes ❑No

vii. Has the patient had inadequate control of asthma symptoms after a minimum of 3 months of compliant use defined as greater than or equal to 50 percent adherence with a corticosteroid inhaler in combination with a long acting beta2-agonist within the past 6 months? ❑Yes ❑No*

If NO, has the patient had inadequate control of asthma symptoms after a minimum of 3 months of compliant use defined as greater than or equal to 50 percent adherence with a corticosteroid inhaler in combination with a long acting muscarinic antagonist within the past 6 months? ❑Yes ❑No

viii. How many injections will the patient need for 112 days (16 weeks)? _____injections for 112 days (16 weeks)

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

i. Has the patient had decreased exacerbations and/or an improvement in symptoms? ❑Yes ❑No

ii. Has the patient been adherent to Dupixent therapy? ❑Yes ❑No

iii. How many injections will the patient need for an 84 day supply? _____ injections for 84 days

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ **DOB:** _____ **Patient ID: R** _____

❑Atopic dermatitis (eczema)

a. Will Dupixent be used in combination with another ***non-topical Prior Authorization (PA) medication? ❑Yes* ❑No

***If YES**, please specify medication: _____

****Non-Topical PA Medications: Adbry (tralokinumab-ldrm), Cibinqo (abrocitinib), Rinvoq (upadactinib)***

b. Has the patient been on this medication continuously for the last **3 months** excluding samples? ***Please select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

i. Is the patient's atopic dermatitis (eczema) moderate to severe? ❑Yes ❑No

ii. Does the patient have a documented baseline evaluation of the condition using one of the following: Investigator's Static Global Assessment (ISGA), Eczema Area and Severity Index (EASI), Patient-Oriented Eczema Measure (POEM) or Scoring Atopic Dermatitis (SCORAD) index? ❑Yes* ❑No

***If YES**, please select a scoring tool and provide the score:

❑**Eczema Area and Severity Index (EASI)** **Score**: _____

❑**Investigator's Static Global Assessment (ISGA)** **Score**: _____

❑**Patient-Oriented Eczema Measure (POEM)** **Score**: _____

❑**Scoring Atopic Dermatitis (SCORAD) index** **Score**: _____

****Please answer ALL that apply to the patient's age below:***

iii. **Age 6 months to less than 2 years**: Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a topical corticosteroid such as desonide or hydrocortisone acetate? ❑Yes ❑No

iv. **Age 2-17**: Please answer the following questions:

1) Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a topical corticosteroid such as desonide or hydrocortisone acetate? ❑Yes ❑No

2) Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a topical calcineurin inhibitor? ❑Yes ❑No

v. **Age 18 or older**: Please answer the following questions:

1) Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a **High** potency topical corticosteroid such as amcinonide, fluocinonide, or halcinonide? ❑Yes ❑No

2) Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a topical calcineurin inhibitor? ❑Yes ❑No

vi. How many injections will the patient need for 112 days (16 weeks)? _____ injections for 112 days (16 weeks)

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

i. Which scoring tool was used to obtain the patient's baseline score: Investigator's Static Global Assessment (ISGA), Eczema Area and Severity Index (EASI), Patient-Oriented Eczema Measure (POEM), or Scoring Atopic Dermatitis (SCORAD) index? ***Please select a scoring tool and answer the following question:***

❑**Eczema Area and Severity Index**: Has there been a decrease from baseline by at least 75%? ❑Yes ❑No

❑**Investigator's Static Global Assessment**: Has there been a decrease from baseline by at least 2 points? ❑Yes ❑No

❑**Patient-Oriented Eczema Measure**: Has there been a decrease from baseline by at least 3 points? ❑Yes ❑No

❑**Scoring Atopic Dermatitis index**: Has there been a decrease from baseline by at least 50%? ❑Yes ❑No

❑**Unknown/Unavailable**

ii. Has the patient been adherent to Dupixent therapy? ❑Yes ❑No

iii. How many injections will the patient need for an 84 day supply? _____ injections for 84 days

PLEASE PROCEED TO PAGE 3 FOR ADDITIONAL DIAGNOSES

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PAGE 3 - PHYSICIAN COMPLETES

Patient Name: _____ **DOB:** _____ **Patient ID: R** _____

❑Chronic rhinosinusitis with nasal polyps (CRSwNP)

a. Will this medication be used in combination with another monoclonal antibody for the treatment of CRSwNP? ❑Yes***** ❑No
If YES, please specify medication: _____

b. Has the patient been on this medication continuously for the last **3 months** excluding samples? ***Please select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

i. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to EACH of the following: a 3-month trial of **TWO** nasal corticosteroid sprays and **ONE** oral corticosteroid? ❑Yes ❑No

ii. Is this medication being prescribed or recommended by an otolaryngologist (ENT)? ❑Yes ❑No

iii. How many injections will the patient need for 112 days (16 weeks)? _____ injections for 112 days (16 weeks)

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

i. Has the patient had an improvement of sino-nasal symptoms? ❑Yes ❑No

ii. Has the patient had a decreased utilization in oral corticosteroids since starting Dupixent? ❑Yes ❑No

iii. Has the patient been adherent to Dupixent therapy? ❑Yes ❑No

iv. How many injections will the patient need for an 84 day supply? _____ injections for 84 days

❑ Chronic obstructive pulmonary disease (COPD)

a. Does the patient have a diagnosis of asthma? ❑Yes* ❑No
If YES, please answer the questions under the diagnosis of **Asthma AND chronic obstructive pulmonary disease (COPD)** on **PAGE 1.**

b. Will this medication be used for the emergency relief of acute bronchospasm? ❑Yes ❑No

c. Will this medication be used in combination with another monoclonal antibody for the treatment of asthma or COPD? ❑Yes***** ❑No
If YES, please specify medication: _____

d. Has the patient been on this medication continuously for the last **3 months** excluding samples? ***Please select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

i. Does the patient have an eosinophil count greater than or equal to 150 cells/mcL in the past 90 days? ❑Yes ❑No*****
If NO, does the patient have an eosinophil count greater than or equal to 300 cells/mcL in the past 12 months? ❑Yes ❑No

ii. Does the patient have oral corticosteroid dependent COPD? ❑Yes ❑No

iii. Has the patient had at least 1 month of daily oral corticosteroid use within the last 3 months? ❑Yes ❑No*****
If NO, does the patient currently require oral corticosteroids? ❑Yes ❑No

iv. Has the patient had 2 or more moderate COPD exacerbations in the past year? ❑Yes ❑No*****
If NO, has the patient had 1 or more severe COPD exacerbations leading to hospitalization in the past year? ❑Yes ❑No

v. Has the patient had inadequate control of asthma symptoms after a minimum of 3 months of compliant use defined as greater than or equal to 50 percent adherence with a long acting beta2-agonist and a long acting muscarinic antagonist in combination with a corticosteroid inhaler within the past 6 months? ❑Yes ❑No*****
If NO, does the patient have a contraindication to inhaled corticosteroids? ❑Yes* ❑No
If YES, has the patient had inadequate control of asthma symptoms after a minimum of 3 months of compliant use defined as greater than or equal to 50 percent adherence with a corticosteroid inhaler in combination with a long acting muscarinic antagonist within the past 6 months? ❑Yes ❑No

vi. How many injections will the patient need for 112 days (16 weeks)? _____injections for 112 days (16 weeks)

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

i. Has the patient had decreased exacerbations and/or an improvement in symptoms? ❑Yes ❑No

ii. Has the patient been adherent to Dupixent therapy? ❑Yes ❑No

iii. How many injections will the patient need for an 84 day supply? _____ injections for 84 days

PLEASE PROCEED TO PAGE 4 FOR ADDITIONAL DIAGNOSES

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PAGE 3 – PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑ Chronic spontaneous urticaria (CSU)

a. Will this medication be used in combination with another monoclonal antibody for the treatment of CSU? ❑Yes* ❑No ***If YES***, please specify the medication:_____

b. Has the patient been on this medication continuously for the last **3 months** excluding samples? ***Please select answer below:***

❑ **NO** – this is **INITIATION** of therapy, please answer the following question:

i. Does the patient have a baseline *urticarial activity score (UAS)? ❑Yes* ❑No
If YES, please specify score: _____
***Urticarial Activity Score:* https://www.mdcalc.com/urticaria-activity-score-uas**

ii. Has the patient remained symptomatic after at least **TWO** previous trials of H1-antihistamines? ❑Yes ❑No

iii. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to Xolair (omalizumab) or a Xolair biosimilar? ❑Yes ❑No

iv. How many injections will the patient need for 112 days (16 weeks)? _____ injections for 112 days (16 weeks)

❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

i. Has the patient been adherent to Dupixent therapy? ❑Yes ❑No

ii. Has the patient's urticaria activity score (UAS) decreased, such as improvement in pruritic wheals, hives, and itching? ❑Yes* ❑No ***If YES***, please specify score: _____
***Urticarial Activity Score:* https://www.mdcalc.com/urticaria-activity-score-uas**

iii. How many injections will the patient need for an 84 day supply? _____ injections for 84 days

❑ Eosinophilic esophagitis (EoE)

a. **Age 1-17**: What is the patient's weight? _____ kg **OR** _____ lbs

b. Has the patient been on this medication continuously for the last **3 months** excluding samples? ***Please select answer below:***

❑ **NO** – this is **INITIATION** of therapy, please answer the following questions:

i. Does the patient have a level greater than or equal to 15 intraepithelial eosinophils per high-power field (eos/hpf)? ❑Yes ❑No

ii. Is the patient showing symptoms of dysphagia such as pain while swallowing, drooling, sensation of food getting stuck in the throat or chest? ❑Yes ❑No

iii. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a proton pump inhibitor (PPI)? ❑Yes ❑No

iv. How many injections will the patient need for 112 days (16 weeks)? _____ injections for 112 days (16 weeks)

❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

i. Has the patient had a decrease in intraepithelial eosinophils per high-powder field (eos/hpf) from baseline? ❑Yes ❑No

ii. Has the patient had an improvement in symptoms of dysphagia? ❑Yes ❑No

iii. Has the patient been adherent to Dupixent therapy? ❑Yes ❑No

iv. How many injections will the patient need for an 84 day supply? _____ injections for 84 days

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PAGE 3 – PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑Prurigo nodularis (PN)

a. Has the patient been on this medication continuously for the last **3 months** excluding samples? ***Please select answer below:***

❑ **NO** – this is **INITIATION** of therapy, please answer the following questions:

i. Does the patient have a documented baseline evaluation of the condition using the Investigator's Global Assessment (IGA) for prurigo nodularis? ❑Yes***** ❑No

****If YES***, what is the patient's score? _____

ii. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a **HIGH** potency topical steroid? ❑Yes ❑No

iii. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to conventional systemic therapy such as cyclosporine or methotrexate*?* ***Please select answer below:***

❑Inadequate response ❑Intolerance or contraindication ❑Has not tried conventional systemic therapy

iv. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to phototherapy?

❑Inadequate response ❑Intolerance or contraindication ❑Patient has not tried phototherapy

v. How many injections will the patient need for 112 days (16 weeks)? _____ injections for 112 days (16 weeks)

❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

i. Has there been a documented improvement of the condition using IGA for prurigo nodularis with a decrease from baseline by at least 2 points? ❑Yes ❑No

ii. Has the patient been adherent to Dupixent therapy? ❑Yes ❑No

iii. How many injections will the patient need for an 84 day supply? _____ injections for 84 days

❑Other ***(please specify)***: _____ ***(please answer the following question)***

a. How many s injections will the patient need for 112 days (16 weeks)? _____ injections(s) for 112 days (16 weeks)

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To ensure a quick and accurate response to your approval request, please **submit medical records (e.g., chart notes, laboratory values)** and use of claims history pertaining to the diagnosis only. Please do not send in medical records of other diagnoses in order to streamline the process. Please use this page as a guideline of what documentation is required to process the prior authorization request.

***For more efficient processing, please provide the page number of the documented information in the medical record**

Documentation Required for ALL diagnoses:

❑**NOT** given concurrently with live vaccines **PAGE _____ of _____**

❑Asthma OR ❑Asthma AND chronic obstructive pulmonary disease (COPD)

- **NOT** used for the relief of acute bronchospasm or status asthmaticus **PAGE _____ of _____**
- **NO** dual therapy with another monoclonal antibody **PAGE _____ of _____**
- **Documentation required for INITIATION of therapy: PAGE _____ of _____**
  - Patient has **ONE** of the following:
    - Eosinophilic phenotype with eosinophil count in the past 90 days **OR** in the past 12 months
    - Oral corticosteroid dependent with **ONE** of the following:
      - ❖ 1 month of daily oral corticosteroid use within the last 3 months **OR** currently requires oral corticosteroids
  - Patient has **ONE** of the following:
    - 2 or more moderate asthma exacerbations in the past year **OR** 1 or more severe asthma exacerbations leading to hospitalization in the past year
  - Inadequate control of symptoms after a minimum of 3 months of compliant use with **ONE** of the following within the past 6 months:
    - Inhaled corticosteroids & long acting beta$_2$ agonist **OR** Inhaled corticosteroids & long acting muscarinic antagonist
- **Documentation required for CONTINUATION of therapy: PAGE _____ of _____**
  - Decreased exacerbation and improvement in symptoms
  - Adherent to Dupixent therapy

❑Atopic dermatitis (AD) (eczema)

- **NOT** used in combination with another non-topical Prior Authorization (PA) medication: Adbry (tralokinumab-ldrm), Cibinqo (abrocitinib), or Rinvoq (upadactinib) **PAGE _____ of _____**
- **Documentation required for INITIATION of therapy: PAGE _____ of _____**
  - Inadequate response, intolerance, or contraindication to **ONE** medication in **EACH** of the following:
    - Topical calcineurin inhibitor (tacrolimus ointment or pimecrolimus cream)
    - Topical corticosteroid (**High** potency for age 18 or older) ***(high potency topical corticosteroid table on PAGE 5)***
  - Baseline evaluation of the condition using **ONE** of the following scoring tools:
    - Eczema Area and Severity Index (EASI): **https://dermnetnz.org/topics/easi-score/**
    - Investigator's Static Global Assessment [ISGA]: **https://www.eczemacouncil.org/assets/docs/Validated-Investigator-Global-Assessment-Scale_vIGA-AD_2017.pdf**
    - Patient-Oriented Eczema Measure (POEM): **https://jamanetwork.com/data/Journals/DERM/11776/dea40003f1.png**
    - Scoring Atopic Dermatitis (SCORAD) index: **https://jamanetwork.com/data/Journals/DERM/11776/dea40003f1.png**
- **Documentation required for CONTINUATION of therapy: PAGE _____ of _____**
  - Improvement of the condition using **ONE** of the following scoring tools: Eczema Area and Severity Index (EASI), Investigator's Static Global Assessment [ISGA], Patient-Oriented Eczema Measure (POEM), or Scoring Atopic Dermatitis (SCORAD) index
  - Adherent to Dupixent therapy

❑Chronic rhinosinusitis with nasal polyps (CRSwNP)

- **NO** dual therapy with another monoclonal antibody **PAGE _____ of _____**
- **Documentation required for INITIATION of therapy: PAGE _____ of _____**
  - Inadequate treatment response, intolerance, or contraindication to a 3-month trial of the following:
    - **TWO** nasal corticosteroid sprays **AND** **ONE** oral corticosteroid
  - Prescribed by or recommended by an otolaryngologist (ENT)
- **Documentation required for CONTINUATION of therapy: PAGE _____ of _____**
  - Improvement in sino-nasal symptoms
  - Decreased utilization of oral corticosteroids
  - Adherent to Dupixent therapy

GUIDELINE CONTINUES ON PAGE 6

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❑ Chronic obstructive pulmonary disease (COPD)

- **NOT** used for the relief of acute bronchospasm **PAGE _____ of _____**
- **NO** dual therapy with another monoclonal antibody **PAGE _____ of _____**
- **Documentation required for INITIATION of therapy: PAGE _____ of _____**
  - Patient has **ONE** of the following:
    - Eosinophilic phenotype with eosinophil count in the past 90 days **OR** in the past 12 months
    - Oral corticosteroid dependent with **ONE** of the following:
      - ❖ 1 month of daily oral corticosteroid use within the last 3 months **OR** currently requires oral corticosteroids
  - Patient has **ONE** of the following:
    - 2 or more moderate COPD exacerbations in the past year **OR** 1 or more severe COPD exacerbations leading to hospitalization in the past year
  - Inadequate control of symptoms after a minimum of 3 months of compliant use with **ONE** of the following within the past 6 months **OR** a contraindication to inhaled corticosteroids:
    - long acting beta2-agonist and a long acting muscarinic antagonist in combination with a corticosteroid inhaler
    - long acting beta2-agonist and a long acting muscarinic antagonist
- **Documentation required for CONTINUATION of therapy: PAGE _____ of _____**
  - Decreased exacerbation and improvement in symptoms
  - Adherent to Dupixent therapy

❑ Chronic spontaneous urticaria (CSU)

- **NO** dual therapy with another monoclonal antibody **PAGE _____ of _____**
- **Documentation required for INITIATION of therapy: PAGE _____ of _____**
  - Symptomatic after at least TWO previous trials of H1-antihistamines
  - Inadequate treatment response, intolerance, or contraindication to Xolair (omalizumab) or a Xolair biosimilar
- **Documentation required for CONTINUATION of therapy: PAGE _____ of _____**
  - Decrease in urticaria activity score (UAS), such as improvement in pruritic wheals, hives, and itching
  - Adherent to Dupixent therapy

❑Eosinophilic esophagitis (EoE)

- Patient's weight **PAGE _____ of _____**
- **Documentation required for INITIATION of therapy: PAGE _____ of _____**
  - Intraepithelial eosinophils per high-power (eos/hpf)
  - Symptoms of dysphagia (e.g., pain while swallowing, drooling, sensation of food getting suck in the throat or chest)
  - Inadequate treatment response, intolerance, or contraindication to a proton pump inhibitor (PPI)
- **Documentation required for CONTINUATION of therapy: PAGE _____ of _____**
  - Decrease in intraepithelial eosinophils per-high-power field (eos/hpf) from baseline
  - Improvement in symptoms of dysphagia
  - Adherent to Dupixent therapy

❑Prurigo nodularis (PN)

- **Documentation required for INITIATION of therapy: PAGE _____ of _____**
  - Inadequate treatment response, intolerance, or contraindication to a **high** potency topical steroid ***(see table below)***
  - Inadequate treatment response, intolerance, or contraindication to conventional systemic therapy
  - Inadequate treatment response, intolerance, or contraindication to phototherapy
  - Baseline evaluation using the Investigator's Global Assessment (IGA)
    - **https://www.medicaljournals.se/acta/html-editor/table-pdf/big/5947/5947_30402.png**
- **Documentation required for CONTINUATION of therapy: PAGE _____ of _____**
  - Improvement using IGA with a decrease from baseline
    - **https://www.medicaljournals.se/acta/html-editor/table-pdf/big/5947/5947_30402.png**
  - Adherent to Dupixent therapy

Relative High Potency of Selected Topical Corticosteroid	
Amcinonide cream/lotion/ointment 0.1%	Diflorasone diacetate cream/ointment (emollient base) 0.05%
Augmented betamethasone dipropionate cream/lotion 0.05%	Fluocinonide cream/gel/ointment 0.05%
Betamethasone dipropionate cream/ointment 0.05%	Halcinonide cream/ointment 0.1%
Betamethasone valerate ointment 0.1%	Triamcinolone acetonide cream/ointment 0.5%
Desoximetasone cream/ointment 0.25%, gel 0.05%	