Reset Form Print Form

New Hampshire Medicaid Fee-for-Service (FFS) Program
Prior Authorization

Dupixent® (dupilumab)

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

FIRST NAME:

MEDICAID ID NUMBER:

DATE OF BIRTH: – –

GENDER: ☐ Male ☐ Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

FIRST NAME:

SPECIALTY:

NPI NUMBER:

PHONE NUMBER: – –

FAX NUMBER: – –

SECTION III: CLINICAL HISTORY

1. Does the patient have a diagnosis of moderate or severe persistent asthma? ☐ Yes ☐ No
   If ***yes***, please answer questions **6–11.**
2. Does the patient have a diagnosis of moderate to severe atopic dermatitis? ☐ Yes ☐ No
   If ***yes***, please answer questions **12–15.**
3. Does the patient have a diagnosis of chronic rhinosinusitis with nasal polyposis? ☐ Yes ☐ No
   If ***yes***, please answer questions **16–20.**
4. Does the patient have a diagnosis of eosinophilic esophagitis? ☐ Yes ☐ No
   If ***yes***, please answer questions **21–22.**

(Form continued on next page.)

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PATIENT LAST NAME: | | | | | | | | | | | | |

PATIENT FIRST NAME: | | | | | | | | | | | | |

SECTION III: CLINICAL HISTORY *(continued)*

5. Does the patient have a diagnosis of prurigo nodularis? ☐ Yes ☐ No
   If ***yes***, please answer questions **23–24.**
6. Is a pulmonologist, allergist, or immunologist prescribing this medication, OR has one of these specialists been consulted in this case? ☐ Yes ☐ No
7. Is the patient symptomatic despite taking medium-to-high dose of inhaled corticosteroids or oral steroids in combination with either a long-acting $beta_2$ agonist, a leukotriene modifier, or theophylline? ☐ Yes ☐ No
   a. If ***yes***, indicate which medication(s) patient is currently taking: ☐ LABA: _____
   ☐ Leukotriene receptor agonist: _____ ☐ Theophylline
8. Is the patient's blood eosinophil result > 150cells/mcL? _____ IU/mL ☐ Yes ☐ No
9. Has the patient had at least one asthma exacerbation in the last year? ☐ Yes ☐ No
10. Does the patient require an oral corticosteroid to manage asthma? ☐ Yes ☐ No
11. Is this patient being treated exclusively for a peanut allergy? ☐ Yes ☐ No
12. Is a dermatologist, immunologist, or allergist prescribing this medication, OR has one been consulted in this case? ☐ Yes ☐ No
13. What is the patient's age? _____
14. Has there been a failure, contraindication, or intolerance to topical corticosteroid therapy? ☐ Yes ☐ No
    a. If ***yes***, describe treatment failure, contraindication, or intolerance and provide date:
    _____
15. Has the patient been treated with topical pimecrolimus, tacrolimus, or Eucrisa® in the past? ☐ Yes ☐ No
    a. If ***yes***, provide drug name and duration of therapy:
    _____
16. Is an ear, nose, and throat (ENT) specialist prescribing this medication, OR has one been consulted in this case? ☐ Yes ☐ No
17. Is the patient ≥ 18 years old? ☐ Yes ☐ No

(Form continued on next page.)

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PATIENT FIRST NAME: | | | | | | | | | | | | |

SECTION III: CLINICAL HISTORY *(continued)*

18. Will Dupixent® (dupilumab) will be used as an add-on maintenance treatment? ☐ Yes ☐ No
19. Has patient had prior sino-nasal surgery OR had treatment with, were ineligible to receive, or were intolerant to systemic corticosteroids within the past 2 years? ☐ Yes ☐ No
20. Has patient had a trial and failure of intranasal steroids? ☐ Yes ☐ No
    a. If ***yes***, provide drug name and duration of therapy:

    _____
21. Is a gastroenterologist, immunologist, or allergist prescribing this medication, OR has one been consulted in this case? ☐ Yes ☐ No
22. Is the patient ≥ 12 years of age AND ≥ 40 kg? ☐ Yes ☐ No
23. Is a dermatologist, immunologist, or allergist prescribing this medication, OR has one been consulted in this case? ☐ Yes ☐ No
24. Is the patient ≥ 18 years old? ☐ Yes ☐ No

Provide any additional information that would help in the decision-making process. If additional space is needed, please use another page.

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PRESCRIBER'S SIGNATURE: _____ **DATE**: _____

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