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 **9-14.**
2. Does the patient have a diagnosis of moderate to severe atopic dermatitis? ☐ Yes ☐ No
   If ***yes***, please answer questions **15–18.**
3. Does the patient have a diagnosis of chronic rhinosinusitis with nasal polyposis? ☐ Yes ☐ No
   If ***yes***, please answer questions **19–23.**
4. Does the patient have a diagnosis of eosinophilic esophagitis? ☐ Yes ☐ No
   If ***yes***, please answer questions **24–25.**

(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 **26–27.**
6. Does the patient have a diagnosis of chronic obstructive pulmonary disease (COPD)? ☐ Yes ☐ No
   If ***yes,*** please answer questions **28–33.**
7. Does the patient have a diagnosis of chronic spontaneous urticaria? ☐ Yes ☐ No
   If ***yes***, please answer question **34.**
8. Does the patient have a diagnosis of bullous pemphigoid? ☐ Yes ☐ No
9. Is a pulmonologist, allergist, or immunologist prescribing this medication, OR has one of these specialists been consulted in this case? ☐ Yes ☐ No
10. 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
11. Is the patient's blood eosinophil result > 150cells/mcL? _____ cells/mcL ☐ Yes ☐ No
12. Has the patient had at least one asthma exacerbation in the last year? ☐ Yes ☐ No
13. Does the patient require an oral corticosteroid to manage asthma? ☐ Yes ☐ No
14. Is this patient being treated exclusively for a peanut allergy? ☐ Yes ☐ No
15. Is a dermatologist, immunologist, or allergist prescribing this medication, OR has one been consulted in this case? ☐ Yes ☐ No
16. What is the patient's age? _____
17. 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:

_____

(Form continued on next page.)

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PATIENT LAST NAME:

PATIENT FIRST NAME:

SECTION III: CLINICAL HISTORY *(continued)*

18. 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:

    _____
19. Is an ear, nose, and throat (ENT) specialist prescribing this medication, OR has one been consulted in this case? ☐ Yes ☐ No
20. Is the patient ≥ 12 years old? ☐ Yes ☐ No
21. Will Dupixent® (dupilumab) be used as an add-on maintenance treatment? ☐ Yes ☐ No
22. 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
23. Has patient had a trial and failure of intranasal steroids? ☐ Yes ☐ No
    a. If ***yes***, provide drug name and duration of therapy:

    _____
24. Is a gastroenterologist, immunologist, or allergist prescribing this medication, OR has one been consulted in this case? ☐ Yes ☐ No
25. Is the patient ≥ 1 year of age AND ≥ 15 kg? ☐ Yes ☐ No
26. Is a dermatologist, immunologist, or allergist prescribing this medication, OR has one been consulted in this case? ☐ Yes ☐ No
27. Is the patient ≥ 18 years old? ☐ Yes ☐ No
28. Is the prescriber a pulmonologist or has one been consulted? ☐ Yes ☐ No
29. Is the patient ≥ 18 years old? ☐ Yes ☐ No
30. Is the baseline FEV-1% predicted between 30%–70%? ☐ Yes ☐ No
31. Is the patient's blood eosinophil result > 300 cells/mcL? _____ cells/mcL _____date
32. Is the patient receiving maximal inhaled therapy (LAMA/LABA/ICS)? ☐ Yes ☐ No

    Start date: _____
    If no, provide reason patient has not received LAMA/LABA/ICS.

    _____
33. Is the patient inadequately controlled? 2 moderate exacerbations (oral corticosteroid or antibiotic) or 1 severe exacerbation (hospitalization or ER visit) in the last 12 months ☐ Yes ☐ No
34. Has the patient had an inadequate response to a first- or second-generation antihistamine? ☐ Yes ☐ No
    a. If ***yes***, please list the antihistamines below with the dates of therapy.

    _____

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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**: _____