reliance|rx®
Specialty Pharmacy Services You Can Rely On
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DUPIXENT® AUTHORIZATION AND RE-AUTHORIZATION REQUEST

TEL: (716) 929-1000 | 1-800-809-4763 FAX: (716) 532-7360

Member Name:	Today's Date:
Date of birth: Sex: Weight:	Prescriber: Prescriber Specialty:
Home Phone Number:	Phone Number: Fax Number:
Home Address/City/State/Zip:	Address/City/State/Zip:
Payor: ☐ Independent Health ☐ Anne Arundel Health System ☐ Pharmacy Benefit Dimensions ☐ Commercial ☐ Medicare ☐ Medicaid ☐ Self-funded Insurance ID: Group Number:	Notes:
	Allergies: ☐ Medication ships to patient's home ☐ Medication ships to provider's office

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis:_____ICD10 Code: _____

☐ **Initial** Dose:_____Frequency: _____

☐ **Maintenance** Dose:_____Frequency: _____

FOR ALL DIAGNOSES:

Please list all treatments related to diagnosis patient has tried and failed

_____

_____

_____

_____

_____

For Prurigo Nodularis:

Does Patient have at least 20 PN lesions total on legs, arms, and/or trunk?

☐ Yes ☐ No

- Please include patient's Worst Itch Numeric Scale Rating (WI-NRS) Score from 0 (no itch) to 10 (worst imaginable itch) within the past week:_____

FOR RE-AUTHORIZATION OF PRURIGO NODULARIS:

Has Patient shown a decreased number of nodules? ☐ Yes ☐ No

- Please provide patient's updated Worst Itch Numeric Scale Rating Score (WI-NRS) from 0 (no itch) to 10 (worst imaginable itch) within the past week:_____

For Chronic Rhinosinusitis with Nasal Polyposis

Is Patient inadequately controlled on intranasal corticosteroids? ☐ Yes ☐ No

FOR RE-AUTHORIZATION OF CHRONIC RHINOSINUSITIS WITH NASAL POLYPOSIS:

- Please provide documentation of continued improvement or maintenance of patient's symptoms

DRUG SELECTION

☐ New Authorization Request ☐ Reauthorization Request

For Eosinophilic Esophagitis:

Is Patient experiencing symptoms of dysphasia? ☐ Yes ☐ No

Has Patient had Endoscopic biopsy documenting peak eosinophils ≥ 15/hpf? ☐ Yes ☐ No

Has Patient tried and failed to respond to a reasonable trial of a proton-pump inhibitor? ☐ Yes ☐ No

FOR RE-AUTHORIZATION OF EOSINOPHILIC ESOPHAGITIS:

Please provide documentation of the following:

- Documentation of decrease in eosinophils/hpf from baseline
- Documented improvement in patient's dysphagia symptoms

For Atopic Dermatitis:

****Please Complete the body surface area diagram on the next page by shading affected areas of body****

Is patient's diagnosis moderate to severe atopic dermatitis? ☐ Yes ☐ No

Does patient have a minimum body surface area involvement of greater than or equal to 10%? ☐ Yes ☐ No

IF YES:

Has patient tried and failed to respond to topical prescription therapies of one moderate to very high potency topical corticosteroid or (1) one calcineurin inhibitor? ☐ Yes ☐ No

Has patient required or failed to respond to at least 12 weeks of treatment with methotrexate, cyclosporine, azathioprine, or mycophenolate mofetil? ☐ Yes ☐ No

Does patient have contraindication to high potency topical corticosteroid, calcineurin inhibitors, methotrexate, cyclosporine, azathioprine, or mycophenolate mofetil? ☐ Yes ☐ No

Has patient required 21 days of oral steroid treatment within a year? ☐ Yes ☐ No

IF NO:

Does Patient have a body surface area involvement of less than 10% that involves the face, ears, eyelids, genitals, intertriginous areas and skin folds? ☐ Yes ☐ No

Has Patient has tried and failed to respond to at least four weeks of a topical calcineurin inhibitor and one topical PDE-4 inhibitor if not otherwise contraindicated? ☐ Yes ☐ No

For Asthma:

Will Patient be using Dupilumab in combination with another monoclonal antibody for the treatment of asthma? ☐ Yes ☐ No

Does patient have a diagnosis of moderate-to-severe asthma with an eosinophilic phenotype or oral corticosteroid dependent asthma? ☐ Yes ☐ No

IF YES:

Has patient experienced greater than or equal to 2 exacerbations within the last 12 months, requiring any of the following despite adherent use of controller therapy (i.e., high dose inhaled corticosteroid (ICS) plus a long acting beta-2 agonist (LABA) or other controller therapy if there is a contraindication/intolerance to a LABA)? (Please check all that apply)

- ☐ Oral/systemic corticosteroid treatment (or an increase in dose if patient is already on oral corticosteroids)
- ☐ Urgent care visit or hospitalization?
- ☐ Intubation?

For patients without oral corticosteroid dependent asthma, patient has an eosinophilic phenotype defined as either of the following:

Does patient have blood eosinophils greater than or equal to 150 cells/mcl within the previous 6 weeks ☐ Yes ☐ No

Does Patient have history of blood eosinophils over 300 cells/mcl?

☐ Yes ☐ No

Will Patient continue use of an inhaled corticosteroid and another controller therapy ☐ Yes ☐ No

FOR RE-AUTHORIZATION OF ASTHMA:

Has Patient demonstrated adherence to asthma controller therapy that includes an ICS plus an additional controller medication (i.e., LABA, leukotriene inhibitor, etc)?

☐ Yes ☐ No

Please provide documentation that patient has shown any of the following:

- Reduction in exacerbations or corticosteroid dose
- Improvement in forced expiratory volume over one second (FEV1) since baseline
- Reduction in the use of rescue therapy

FOR RE-AUTHORIZATION FOR ATOPIC DERMATITIS:

Has the patient showed continued improvement or maintenance of disease status such as reduced pruritus, erythema, eczema, excoriation, lichenification, or decreased need for other topical or systemic therapies with steroids or immunosuppressives? ☐ Yes ☐ No

Has Patient shown a response after the first 16 week trial? ☐ Yes ☐ No

IF NO:

Has Patient shown a response after 1 additional six-month trial? ☐ Yes ☐ No