



New Hampshire AIDS Drug Assistance 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

- Does the patient have a diagnosis of moderate or severe persistent asthma? Yes No
If **yes**, please answer questions **6–11**.
- Does the patient have a diagnosis of moderate to severe atopic dermatitis? Yes No
If **yes**, please answer questions **12–15**.
- Does the patient have a diagnosis of chronic rhinosinusitis with nasal polyposis? Yes No
If **yes**, please answer questions **16–20**.
- 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:

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PATIENT FIRST NAME:

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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 beta₂ 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:

_____ Yes No

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:

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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: _____