

SENTARA COMMUNITY PLAN (MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-800-750-9692.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Dupixent® (dupilumab)

Pre-filled pen: for use in adult and pediatric patients 2 years and older

Pre-filled syringe: for use in adult and pediatric patients 6 months and older

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Weight (if applicable): _____ Date weight obtained: _____

Diagnosis: Check box below that applies to diagnosis

DIAGNOSIS	Recommended Dose
<input type="checkbox"/> Allergic Fungal Rhinosinusitis (Pediatric: Ages 6-17 based on weight)	<ul style="list-style-type: none"> 15 to < 30kg: 300 mg once every 4 weeks 30 to < 60kg: 200 mg once every other week ≥ 60kg: 300 mg once every other week Note: For pediatric patients 6 months to 11 years of age, the pre-filled syringe should be administered by a caregiver

(Continued on next page)

DIAGNOSIS	Recommended Dose
<p>❑ Atopic Dermatitis (Adults) – Moderate to Severe</p>	<ul style="list-style-type: none"> • Initial: 600 mg (given as two 300 mg injections) • Maintenance: 300 mg once every other week 2 prefilled syringes for the initial dose, then 1 single dose syringe every 14 days
<p>❑ Atopic Dermatitis (Pediatric: Ages 6 months to 5 years old based on weight)-Moderate to Severe</p>	<ul style="list-style-type: none"> • No initial loading dose is recommended • 5 to < 15kg: 200mg (one 200mg injection) every 4 weeks • 15 to < 30 kg: 300mg (one 300mg injection) every 4 weeks
<p>❑ Atopic Dermatitis (Pediatric: Ages 6-17 based on weight) – Moderate to Severe</p>	<ul style="list-style-type: none"> • Initial: 15 to < 30kg: 600 mg (given as two 300 mg injections) • Maintenance: 15 to < 30kg: 300 mg once every 4 weeks • Initial: 30 to < 60kg: 400 mg (given as two 200 mg injections) • Maintenance: 30 to < 60kg: 200 mg once every other week • Initial: ≥ 60kg: 600 mg (given as two 300 mg injections) • Maintenance: ≥ 60kg: 300 mg once every other week • Note: For pediatric patients 6 months to 11 years of age, the pre-filled syringe should be administered by a caregiver
<p>❑ Asthma – Moderate to Severe</p>	<ul style="list-style-type: none"> • Initial: 400 mg (given as two 200 mg injections) or 600 mg (given as two 300 mg injections) • Maintenance: 200 mg (following 400 mg initial dose) or 300 mg (following 600 mg initial dose) once every other week 2 prefilled syringes for the initial dose, then 1 single dose syringe every 14 days
<p>❑ Bullous Pemphigoid</p>	<ul style="list-style-type: none"> • Initial: 600 mg (given as two 300 mg injections) • Maintenance: 300 mg once every other week
<p>❑ Chronic Rhinosinusitis with Nasal Polyposis</p>	<ul style="list-style-type: none"> • 300 mg SC once every other week • *200 mg syringes are NOT approved for Chronic Rhinosinusitis with Nasal Polyposis
<p>❑ Chronic Spontaneous Urticaria (Pediatric: Ages 2-5 years old based on weight)</p>	<ul style="list-style-type: none"> • No initial loading dose is recommended • 5 to < 15kg: 200mg (one 200mg injection) every 4 weeks • 15 to < 30 kg: 300mg (one 300mg injection) every 4 weeks

(Continued on next page)

DIAGNOSIS	Recommended Dose
<input type="checkbox"/> Chronic Spontaneous Urticaria (Pediatric: Ages 6-17 years old based on body weight)	<ul style="list-style-type: none"> • Initial: 15 to < 30kg: 600 mg (given as two 300 mg injections) • Maintenance: 15 to < 30kg: 300 mg once every 4 weeks • Initial: 30 to <60kg: 400 mg (given as two 200 mg injections) • Maintenance: 30 to <60kg: 200 mg once every other week • Initial: ≥60kg: 600 mg (given as two 300 mg injections) • Maintenance- ≥60kg: 300 mg once every other week
<input type="checkbox"/> Chronic Obstructive Pulmonary Disease (COPD)	<ul style="list-style-type: none"> • 300mg SC every other week
<input type="checkbox"/> Eosinophilic Esophagitis (EoE) Children ≥1 year, Adolescents and Adults	<ul style="list-style-type: none"> • 15 to <30kg: Initial and Maintenance: 200 mg once every other week • 30 to <40kg: Initial and Maintenance: 300mg once every other week • 40kg or more: 300mg SC every week
<input type="checkbox"/> Prurigo Nodularis (PN)	<ul style="list-style-type: none"> • Initial: 600 mg once (given as two 300 mg injections) • Maintenance: 300 mg SC once every other week

Sentara Health Plans considers the use of concomitant therapy with Cinqair®, Nucala®, Fasentra®, Xolair®, Tezspire™ and Exdensur to be experimental and investigational. Safety and efficacy of these combinations have NOT been established and will NOT be permitted. In the event a member has an active Cinqair®, Fasentra®, Nucala®, Tezspire™, Xolair® or Exdensur authorization on file, all subsequent requests will NOT be approved.

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Diagnosis: Allergic Fungal Rhinosinusitis

Initial Authorization: 12 months

- Member is 6 years of age or older
- Diagnosis of Allergic Fungal Rhinosinusitis
- Member has a history of sino-nasal surgery

(Continued on next page)

Diagnosis: Moderate-to-Severe Atopic Dermatitis

Initial Authorization: 12 months

- Diagnosis of moderate-to-severe atopic dermatitis

AND

Please check age for appropriate trial and failure therapy:

- Member is 6 months to under 2 years of age**
- Prior documented trial and failure of 30 days of:
 - One (1) topical corticosteroid
 - Member is 2 years of age and older**
 - Prior documented trial and failure of 30 days of ONE of the following:
 - One (1) topical corticosteroid of medium to high potency (e.g., mometasone, triamcinolone)
 - One (1) topical calcineurin inhibitor (tacrolimus or pimecrolimus)

Diagnosis: Moderate-to-Severe Asthma

Quantity Limit: 2 prefilled syringes for the initial dose; then 1 single-dose syringe every 14 days

Initial Authorization: 12 months

- Member is ≥ 6 years of age
- Patient must have moderate to severe asthma diagnosed as ONE of the following types:
- Eosinophilic phenotype and baseline blood eosinophil count ≥ 150 cells/mcl
 - Oral corticosteroid dependent asthma with at least 1 month of daily oral corticosteroid use within the last 3 months

Diagnosis: Chronic Rhinosinusitis with Nasal Polyposis

Initial Authorization: 12 months

- Member is ≥ 12 years of age
- Physician has assessed the baseline disease severity utilizing an objective measure/tool
- Member has inadequate response after 3 consistent months use of preferred PDL intranasal steroids or oral corticosteroids
- Member is concurrently treated with intranasal corticosteroids

(Continued on next page)

Diagnosis: Eosinophilic Esophagitis (EoE)

Initial Authorization: 12 months

- Prescribed by or in consultation with an allergist or gastroenterologist
- Member is 1 year of age or older and weighs at least 15 kg
- Member has a diagnosis of EoE
- Member did not respond clinically to treatment with a topical glucocorticosteroids or proton pump inhibitor

Diagnosis: Prurigo Nodularis (PN)

Initial Authorization: 12 months

- Member is 18 years of age or older
- Member has a diagnosis of Prurigo Nodularis (PN)
- Prescribed by or in consultation with a dermatologist, allergist, or immunologist

Chronic Obstructive Pulmonary Disease (COPD) and an eosinophilic phenotype

Initial Authorization: 12 months

- Member is 18 years of age or older
- Prescribed by or in consultation with a pulmonologist
- Member has a diagnosis of COPD that is inadequately controlled and a minimum blood eosinophil count of 300 cells/mcL at screening, measured within the past 12 months
- Member is receiving maximal inhaled therapy consisting of a long-acting muscarinic antagonist (LAMA), long-acting beta agonist (LABA), and inhaled corticosteroid (ICS) (or therapy of LAMA plus LABA if ICS is contraindicated)

Chronic Spontaneous Urticaria

Initial Authorization: 12 months

- Member is 2 years of age or older
- Member has a diagnosis of Chronic Spontaneous Urticaria
- Member had a 30-day trial and failure, or intolerance to H1 antihistamine treatment

(Continued on next page)

Bullous Pemphigoid

Initial Authorization: 12 months

- Member is 18 years of age or older
- Member has a diagnosis of Bullous Pemphigoid

All Diagnoses

Reauthorization: 12 months. Check below all that apply. All criteria must be checked for approval. To support each line checked, all documentation (lab results, diagnostics, and/or chart notes) must be provided or request may be denied.

- Member has experienced therapeutic benefit from the requested medication

Medication being provided by Specialty Pharmacy - PropriumRx

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****