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
❑ **Atopic Dermatitis (Adults) – Moderate to Severe**	• **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
❑ **Atopic Dermatitis (Pediatric: Ages 6 months to 5 years old based on weight)- Moderate to Severe**	• **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

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DIAGNOSIS	Recommended Dose
❑ **Atopic Dermatitis (Pediatric: Ages 6- 17 based on weight) – Moderate to Severe**	• **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
❑ **Asthma – Moderate to Severe**	• **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
❑ **Bullous Pemphigoid**	• **Initial:** 600 mg (given as two 300 mg injections) • **Maintenance:** 300 mg once every other week
❑ **Chronic Rhinosinusitis with Nasal Polyposis**	• 300 mg SC once every other week • *200 mg syringes are NOT approved for Chronic Rhinosinusitis with Nasal Polyposis
❑ **Chronic Spontaneous Urticaria**	• **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
❑ **Chronic Obstructive Pulmonary Disease (COPD)**	• 300mg SC every other week

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DIAGNOSIS	Recommended Dose
❑ **Eosinophilic Esophagitis (EoE) Children ≥1 year, Adolescents and Adults**	• **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
❑ **Prurigo Nodularis (PN)**	• **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®, Fasenra®, Xolair®, and Tezspire™ 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®, Fasenra®, Nucala®, Tezspire™ or Xolair® 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: 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

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❑ **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

❑ **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)

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❑ **Chronic Spontaneous Urticaria**
Initial Authorization: 12 months

- ❑ Member is 12 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

❑ **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
- ❑ Member is free of toxicity 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.*

REVISED/UPDATED/REFORMATTED: ~~6/29/2017; 7/11/2017; 8/28/2017; 8/17/2018; 6/20/2019; 12/24/2019; 12/21/2020; 6/29/2021; 12/7/2021; 1/6/2022; 1/12/2022; 4/21/2022; 6/27/2022; 7/14/2022; 9/26/2022; 11/9/2022; 12/27/2022; 9/20/2023; 2/5/2024; 9/24/2024, 10/03/2024~~, ~~12/112024,~~ **12/13/2025**