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:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

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
❑ **Chronic Rhinosinusitis with Nasal Polyposis**	• 300 mg SC once every other week • *200 mg syringes are NOT approved for Chronic Rhinosinusitis with Nasal Polyposis
❑ **Eosinophilic Esophagitis (EoE)**	• 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.

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❑ **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 for:
    - ❑ One (1) topical corticosteroid
- ❑ **Member is 2 years of age and older**
  - ❑ Prior documented trial and failure of 30 days for:
    - ❑ One (1) topical corticosteroid of medium to high potency (e.g., mometasone, triamcinolone)

OR

- ❑ 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

AND

- ❑ Patient must have moderate to severe asthma diagnosed as ONE of the following types:
  - ❑ Eosinophilic phenotype and baseline blood eosinophil count ≥ 150 cells/mcl

OR

- ❑ Oral corticosteroid dependent asthma with at least 1 month of daily oral corticosteroid use within the last 3 months

AND

- ❑ Dupixent® is an addition to current maintenance treatment

❑ **Diagnosis: Chronic Rhinosinusitis with Nasal Polyposis**

Initial Authorization: 12 months

- ❑ Member is ≥**18** years of age

AND

- ❑ Physician has assessed the baseline disease severity utilizing an objective measure/tool

AND

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- ❑ Member has inadequate response after 3 consistent months use of preferred PDL intranasal steroids or oral corticosteroids

AND

- ❑ Member is concurrently treated with intranasal corticosteroids

AND

- ❑ Dupixent® is an addition to current maintenance treatment

❑ **Diagnosis: Eosinophilic Esophagitis (EoE).**

Initial Authorization: 12 months

- ❑ Prescribed by or in consultation with an allergist or gastroenterologist

AND

- ❑ Member is 1 year of age or older and weighs at least 15 kg

AND

- ❑ Member has a diagnosis of EoE

AND

- ❑ 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

AND

- ❑ Member has a diagnosis of Prurigo Nodularis (PN)

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.****