Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Dupixent (dupilumab) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 6 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Dupixent (dupilumab).** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: ______________________________ Kaiser Medical ID#: _________________ Date of Birth: _____________

2 – Provider Information

Is the prescriber a Pulmonologist, ENT Specialist, Allergist, Gastroenterologist or Dermatologist? □ No □ Yes

If consulted with a specialist, specialist name and specialty: ____

Provider Name: ______________________________ Specialty: _________________________ NPI: __________________

Provider Address: ____

Provider Phone #: __________________________Provider Fax #: ___________________________

3 – Pharmacy Information

Pharmacy Name: ________________________________ Pharmacy NPI: ____

Pharmacy Phone #_______________________________ Pharmacy Fax #: ____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: ____
Sig: ____

Drug 2: Name/Strength/Formulation: ____
Sig: ____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?

   □ Initial therapy □ Continuing therapy, State date: ________________________

2. Indicate the patient's diagnosis for the requested medication: ____

Clinical Criteria:
Asthma:

1. Member has diagnosis of uncontrolled moderate to severe asthma defined as any of the following:
   a. ≥2 exacerbations in the past 12 months requiring systemic corticosteroids for more than 3 days
   b. ≥1 asthma exacerbation(s) leading to hospitalization in the past 12 months
   c. Dependence on daily oral corticosteroids (OCS) for asthma control
   d. Poor symptom control (ACT score less than 20)

   □ No □ Yes

2. AND member has uncontrolled asthma despite good adherence (at least 75% over the past 3 months) to a regimen containing: a high dose inhaled corticosteroid, long-acting beta 2 agonist, AND long-acting muscarinic antagonist, and consideration given to use of a leukotriene receptor antagonist,
   □ No □ Yes

3. Member is ≥ 6 years,
   □ No □ Yes

4. AND Dupixent will NOT be used with Fasenra (benralizumab), Cinqair (resilizumab), Xolair (omalizumab), Nucala (mepolizumab), or Tezspire (tezepelumab-ekko),
   □ No □ Yes

5. AND Dupixent is being used for one of the following indications:
   a. Eosinophilic asthma (non-OCS dependent) with eosinophil count ≥150 cells/microliter in the past 12 months,
   b. OR OCS-dependent asthma (no minimum serum eosinophil requirement)
   c. OR clinical diagnosis of allergic asthma AND requiring high-dose Xolair (i.e. q2week dosing frequency)

   □ No □ Yes

6. AND if using for eosinophilic asthma and aged ≥12 years: requires documented treatment failure, contraindication, or inadequate response to Fasenra
   □ No □ Yes

Atopic Dermatitis/Eczema:

1. Member has diagnosis of moderate to severe atopic dermatitis,
   □ No □ Yes

2. AND history of failure, contraindication, or intolerance to at least one of the following topical therapies:
   a. Medium to very-high potency topical steroids
   b. Topical calcineurin inhibitor

   □ No □ Yes

3. AND member has history of failure, inadequate response, contraindication, or intolerance to narrow-band short wave ultraviolet B light (NB-UV light); *history of worsening eczema with sunlight/heat is considered contraindication*

   □ No □ Yes

<u>Additional criteria if patient is ≥18 years:</u>

4. History of inadequate response (after at least 1 month of treatment), intolerance, or contraindication (i.e. pregnancy/breastfeeding, history of alcoholism or alcoholic liver disease, chronic liver disease, immunodeficiency syndrome, pre-existing blood dyscrasia, hemodialysis, or end-stage renal disease) to methotrexate.

   □ No □ Yes

Prurigo Nodularis:

1. Prescriber is a Dermatologist,
   □ No □ Yes

2. AND diagnosis of prurigo nodularis (PN) for at least 3 months with widespread distribution (BSA involvement ≥ 20%) and severe itch,
   □ No □ Yes

3. AND patient is at least 18 years old,
   □ No □ Yes

4. AND inadequate response or contraindication to at least 3-month trial of phototherapy unless involvement in sensitive areas (e.g. face, body folds, etc.),
   □ No □ Yes

5. AND failed at least 3-month trial of one of the following unless clinically significant adverse effects or contraindications (i.e. pregnancy/breastfeeding, history of alcoholism or alcoholic liver disease, chronic liver disease, immunodeficiency syndrome, pre-existing blood dyscrasia, hemodialysis, or end-stage renal disease):
   - Methotrexate
   - Cyclosporine

   □ No □ Yes

Chronic Rhinosinusitis with Polyps:

1. Member has diagnosis of rhinosinusitis (chronic) with polyps
   □ No □ Yes

Eosinophilic Esophagitis:

1. Prescriber is an Allergist or Gastroenterologist,
   □ No □ Yes

2. AND patient is at least 12 years old,
   □ No □ Yes

3. AND patient weighs at least 40 kg,
   □ No □ Yes

4. AND patient has contraindication, intolerance, or did not respond clinically to treatment with at least an 8-week trial of a topical glucocorticosteroid (i.e. swallowed fluticasone, budesonide),
   □ No □ Yes

5. AND patient has contraindication, intolerance, or did not respond clinically to treatment with at least an 8-week trial of a proton pump inhibitor
   □ No □ Yes

For continuation of therapy, please respond to <u>additional questions</u> below:

1. Member has documentation of positive clinical response to therapy,
   □ No □ Yes

2. AND member followed up with a specialist in the past 12 months since last review
   □ No □ Yes

6 – Provider Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

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I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	**Date:**

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