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

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Dupixent (dupilumab).** Please complete and 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 this form is complete. The KP-MAS Formulary can be found at:** Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Member Information

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

2 – Provider Information

Provider Name: ______________________________ Specialty: _____________________Provider NPI: _________________

Provider Address: ____

Provider Phone #: _________________________Provider Fax #: ___________________________

3 – Pharmacy Information

Pharmacy Name: ________________________________ Pharmacy NPI: __________________________________

Pharmacy Phone #_______________________________ Pharmacy Fax #: __________________________________

4 – Drug Therapy Requested

Name/Strength/Formulation: ____

Sig: ____

5 – Diagnosis

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

6 – Clinical Criteria

Atopic Dermatitis

2. Is the member ≥ 6 months of age

☐ Yes ☐ No

3. Does the member have a diagnosis of atopic dermatitis? **AND**

☐ Yes ☐ No

4. Prior documented trial for 30 days and failure or contraindication to:
   a. Topical corticosteroid of medium to high potency (e.g., mometasone, fluocinolone) **AND**
      ☐ Yes ☐ No
   b. Topical calcineurin inhibitors (tacrolimus or pimecrolimus); **AND**
      ☐ Yes ☐ No

   If no, provide explanation: ____

Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP)

5. Is the member ≥18 years of age?

☐ Yes ☐ No

6. Does the patient have poorly controlled Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP)?

☐ Yes ☐ No

7. Prior documented trial and inadequate response after 3 consistent months use of:
   a. Intranasal steroids or oral corticosteroids, **OR**
      ☐ Yes ☐ No
   b. Concurrently treated with intranasal corticosteroids
      ☐ Yes ☐ No

   If no, provide explanation: ____

8. Is Dupixent being prescribed in addition to maintenance therapy?

☐ Yes ☐ No

   a. If yes, please document below:

Name/Strength/Formulation: ____

Sig: ____

Asthma

9. Is the member ≥6 years of age? **AND**

☐ Yes ☐ No

10. Is the member pregnant?

☐ Yes ☐ No

11. Does the member have moderate to severe asthma diagnosed as one of the following types?
    a. Asthma with eosinophilic phenotype with eosinophilic count ≥ 150 cells/mcL, **OR**
    b. Oral corticosteroid dependent asthma with at least 1 month od daily oral corticosteroid use within the last 3 months

☐ Yes ☐ No

If no, provide explanation: ____

Eosinophilic Esophagitis (EoE)

12. Is the member ≥ 12 years of age? **AND**

☐ Yes ☐ No

13. Is the member's weight ≥ 40 kg, **AND**

☐ Yes ☐ No

14. Has the member failed response to treatment with corticosteroid or proton pump inhibitor?

☐ Yes ☐ No

15. Is therapy prescribed by or in consultation with an allergist or gastroenterologist?

☐ Yes ☐ No

Prurigo Nodularis (PN)

16. Is the member ≥18 years of age?

☐ Yes ☐ No

17. Does the member have a diagnosis of Prurigo Nodularia (PN)

☐ Yes ☐ No

7 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If the member has not tried the preferred agent(s) please provide a 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.

Prescriber Signature:	**Date:**

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