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CardinalCare
Virginia's Medicaid Program

COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Service Authorization (SA) Form

Dupixent®

If the following information is not coplete, correct, or legible, the SA process can be delayed.

Please use one form per member.

Dupixent for atopic dermatitis has an electronic edit and does not require submission of this fax form; this form is for other indications. Length of Authorization = 1 year.

MEMBER INFORMATION

Last Name: _____

First Name: _____

Medicaid ID Number: _____

Date of Birth: _____

Expected Pregnancy Term Date: _____

Requested Start Date: _____

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name: _____

First Name: _____

NPI Number: _____

Phone Number: _____

Fax Number: _____

DIAGNOSIS AND MEDICAL INFORMATION

For a diagnosis of chronic rhinosinusitis with nasal polyps only:

1. Is the member 12 years of age or older?
   ☐ Yes ☐ No
2. Does the member have inadequate response after 3 consistent months' use of preferred intranasal steroids or oral corticosteroids?
   ☐ Yes ☐ No
3. Is the member concurrently being treated with intranasal corticosteroids?
   ☐ Yes ☐ No
4. Has the physician assessed baseline disease severity utilizing an objective measurement/tool?
   ☐ Yes ☐ No

(Form continued on next page)

Member's Last Name: **Member's First Name:**

For a diagnosis of moderate to severe asthma:

1. Is the member 6 years of age or older?
   ☐ Yes ☐ No
2. Does the member have a diagnosis of moderate to severe asthma with either:
   - Asthma with eosinophilic phenotype with 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

   ☐ Yes ☐ No

For a diagnosis of eosinophilic esophagitis (EoE):

1. Is the member 1 year of age or older?
   ☐ Yes ☐ No
2. Does the member weigh ≥ 15 kg?
   ☐ Yes ☐ No
3. Is Dupixent prescribed by or in consultation with an allergist or gastroenterologist?
   ☐ Yes ☐ No
4. Has the member responded clinically to treatment with a topical glucocorticosteroid or proton pump inhibitor?
   ☐ Yes ☐ No

For adult members with inadequately controlled chronic obstructive pulmonary disease (COPD) and an eosinophilic phenotype:

1. Is the member 18 years of age or older?
   ☐ Yes ☐ No
2. Is Dupixent prescribed by or in consulation with a pulmonologist?
   ☐ Yes ☐ No
3. Does the member have 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?
   ☐ Yes ☐ No
4. Is the member 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)?
   ☐ Yes ☐ No
5. Does the member have a history of at least 2 moderate (requiring treatment with systemic corticosteroids and/or antibiotics) or 1 severe exacerbation(s) (resulting in hospitalization or observation for over 24 hours in an emergency department or urgent care facility) in the previous year, with 1 exacerbation occurring while the member was on maximal inhaled therapy?
   ☐ Yes ☐ No

Member's Last Name: Member's First Name:

For adult members with a diagnosis of prurigo nodularis (PN):

1. Is the member 18 years of age or older?
   ☐ Yes ☐ No
2. Does the member have a diagnosis of PN?
   ☐ Yes ☐ No
3. Is Dupixent prescribed by or in consultation with a dermatologist, allergist, or immunologist?
   ☐ Yes ☐ No

For renewal:

1. Has the member experienced a therapeutic benefit from the requested medication?
   ☐ Yes ☐ No
2. Is the member free of toxicity from the requested medication?
   ☐ Yes ☐ No

Prescriber Signature (Required) **Date**

By signature, the Physician confirms the above information is accurate and verifiable by patient records.

Please include ALL requested information; Incomplete forms will delay the SA process.

Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

The completed form may be: **FAXED TO 800-932-6651**, phoned to 800-932-6648, or mailed to:
Prime Therapeutics Management LLC/Attn: GV – 4201
P.O. Box 64811, St. Paul, MN 55164-0811