Prescriber Criteria Form

Dupixent 2025 PA Fax 1691-A v4 010125.docx
Dupixent (dupilumab)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Dupixent (dupilumab).

Drug Name:
Dupixent (dupilumab)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.

1	Has the patient been diagnosed with moderate-to-severe atopic dermatitis? [If no, then skip to question 6.]	Yes	No
2	Is the patient 6 months of age or older? [If no, then no further questions.]	Yes	No
3	Is this a request for continuation of therapy with the requested drug? [If no, then skip to question 5.]	Yes	No
4	Has the patient achieved or maintained a positive clinical response? [No further questions.]	Yes	No
5	Does the patient meet either of the following prior to initiation with the requested drug: A) patient has had an inadequate treatment response to either a topical corticosteroid or a topical calcineurin inhibitor, B) topical corticosteroids and topical calcineurin inhibitors are not advisable for the patient? [No further questions.]	Yes	No
6	Has the patient been diagnosed with oral corticosteroid dependent asthma? [If no, then skip to question 10.]	Yes	No

7	Is this a request for continuation of therapy with the requested drug? [If yes, then skip to question 15.]	Yes	No
8	Does the patient have inadequately controlled asthma despite current treatment with both of the following medications: A) high-dose inhaled corticosteroid, B) additional controller (long acting beta2-agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained release theophylline)? [If yes, then skip to question 16.]	Yes	No
9	Does the patient have an intolerance or contraindication to both of the following therapies: A) high-dose inhaled corticosteroid, B) additional controller (long acting beta2-agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline)? [If yes, then skip to question 16.] [If no, then no further questions.]	Yes	No
10	Has the patient been diagnosed with moderate-to-severe asthma? [If no, then skip to question 17.]	Yes	No
11	Is this a request for continuation of therapy with the requested drug? [If yes, then skip to question 15.]	Yes	No
12	Is the patient's baseline blood eosinophil count at least 150 cells per microliter? [If no, then no further questions.]	Yes	No
13	Does the patient have inadequately controlled asthma despite current treatment with both of the following medications: A) medium-to-high-dose inhaled corticosteroid, B) additional controller (long acting beta2-agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline)? [If yes, then skip to question 16.]	Yes	No
14	Does the patient have an intolerance or contraindication to both of the following therapies: A) medium-to-high-dose inhaled corticosteroid, B) additional controller (long acting beta2-agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline)? [If yes, then skip to question 16.] [If no, then no further questions.]	Yes	No
15	Has the patient's asthma control improved on treatment with the requested drug, as demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations or a reduction in the daily maintenance oral corticosteroid dose? [If no, then no further questions.]	Yes	No
16	Is the patient 6 years of age or older? [No further questions.]	Yes	No
17	Does the patient have a diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP)? [If no, then skip to question 21.]	Yes	No

18	Will the requested drug be used as an add-on maintenance treatment? [If no, then no further questions.]	Yes	No
19	Has the patient experienced an inadequate treatment response to Xhance (fluticasone)? [If no, then no further questions.]	Yes	No
20	Is the patient 18 years of age or older? [No further questions.]	Yes	No
21	Is the requested drug being prescribed for the treatment of eosinophilic esophagitis? [If no, then skip to question 29.]	Yes	No
22	Is the patient 1 year of age or older? [If no, then no further questions.]	Yes	No
23	Is this a request for continuation of therapy with the requested drug? [If no, then skip to question 25.]	Yes	No
24	Has the patient achieved or maintained a positive clinical response? [No further questions.]	Yes	No
25	Has the diagnosis been confirmed by esophageal biopsy characterized by greater than or equal to 15 intraepithelial esophageal eosinophils per high power field? [If no, then no further questions.]	Yes	No
26	Is the patient exhibiting clinical manifestations of the disease (for example, dysphagia)? [If no, then no further questions.]	Yes	No
27	Does the patient weigh at least 15 kilograms? [If no, then no further questions.]	Yes	No
28	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to a topical corticosteroid? [No further questions.]	Yes	No
29	Is the requested drug being prescribed for the treatment of prurigo nodularis? [If no, then no further questions.]	Yes	No
30	Is the patient 18 years of age or older? [If no, then no further questions.]	Yes	No
31	Is this a request for continuation of therapy with the requested drug? [If no, then skip to question 33.]	Yes	No
32	Has the patient achieved or maintained a positive clinical response? [No further questions.]	Yes	No
33	Does the patient meet either of the following prior to initiation with the requested drug: A) patient has had an inadequate treatment response to a topical corticosteroid, B) topical corticosteroids are not advisable for the patient?	Yes	No

Comments:	

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: ________________________________ Date:____________________