Prescriber Criteria Form Dupixent 2025 PA Fax 1691-A v5 020125.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 (i.e., 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 (i.e., 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 (i.e., 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 (i.e., 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 22.]	Yes ◯	No ◯
18	Will the requested drug be used as an add-on maintenance treatment? [If no, then no further questions.]	Yes ◯	No ◯

19	Is the patient 12 years of age or older? [If no, then no further questions.]	Yes ◯	No ◯
20	Is the patient 18 years of age or older? [If no, then no further questions.]	Yes ◯	No ◯
21	Has the patient experienced an inadequate treatment response to Xhance (fluticasone)? [No further questions.]	Yes ◯	No ◯
22	Is the requested drug being prescribed for the treatment of eosinophilic esophagitis? [If no, then skip to question 30.]	Yes ◯	No ◯
23	Is the patient 1 year of age or older? [If no, then no further questions.]	Yes ◯	No ◯
24	Is this a request for continuation of therapy with the requested drug? [If no, then skip to question 26.]	Yes ◯	No ◯
25	Has the patient achieved or maintained a positive clinical response? [No further questions.]	Yes ◯	No ◯
26	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 ◯
27	Is the patient exhibiting clinical manifestations of the disease (for example, dysphagia)? [If no, then no further questions.]	Yes ◯	No ◯
28	Does the patient weigh at least 15 kilograms? [If no, then no further questions.]	Yes ◯	No ◯
29	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 ◯
30	Is the requested drug being prescribed for the treatment of prurigo nodularis? [If no, then skip to question 35.]	Yes ◯	No ◯
31	Is the patient 18 years of age or older? [If no, then no further questions.]	Yes ◯	No ◯
32	Is this a request for continuation of therapy with the requested drug? [If no, then skip to question 34.]	Yes ◯	No ◯
33	Has the patient achieved or maintained a positive clinical response? [No further questions.]	Yes ◯	No ◯
34	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? [No further questions.]	Yes ◯	No ◯

35	Has the patient been diagnosed with chronic obstructive pulmonary disease (COPD)? [If no, then no further questions.]	Yes ◯	No ◯
36	Is the patient 18 years of age or older? [If no, then no further questions.]	Yes ◯	No ◯
37	Is this a request for continuation of therapy with the requested drug? [If yes, then skip to question 40.]	Yes ◯	No ◯
38	Is the patient currently receiving either of the following: A) standard inhaled triple therapy (i.e., inhaled glucocorticoid, long-acting muscarinic antagonist, long acting beta2-agonist), B) a long-acting muscarinic antagonist and long acting beta2-agonist, and has a contraindication to inhaled glucocorticoid? [If no, then no further questions.]	Yes ◯	No ◯
39	Is the patient's absolute blood eosinophil count at least 300 cells per microliter prior to initiation with the requested drug? [No further questions.]	Yes ◯	No ◯
40	Has the patient achieved or maintained a positive clinical response?	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:**_____