Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

**Horizon NJ Health**
**Dupilumab (Dupixent) – Medical Necessity Request**
****Complete page 1,2, 3 and 4 only for New/Initial Requests****

1. What is the prescriber's specialty managing the medication?
□ Allergy □ Pulmonology □ Dermatology □ Gastroenterology
□ Otolaryngologist (ears, nose, and throat) specialist □ Other: _____

## Diagnosis

□ **Atopic Dermatitis (Eczema)**

a. Please indicate the severity of atopic dermatitis: □ mild □ moderate □ severe

b. Is at least 10% of the member's body surface area affected? **Yes or No**

c. Does the member have clinically difficult to treat areas (e.g., face, neck, genital) that interfere with quality of life? **Yes** or **No**

   a. If **Yes:** What are the affected areas?

_____

d. Has the member tried and failed topical corticosteroid therapy for the diagnosis provided?
□ **Yes**: Please provide what topical therapies (name, strength, and dosage form) the member has failed.

_____

□ **No**: Can the member try a medium to very high potency topical corticosteroid (e.g. mometasone ointment 0.1%, betamethasone dipropionate ointment 0.05%, etc) instead?
□ **Yes**: Please notify the pharmacy of the change and return the form.
□ **No**: Please providereason why:.

_____

e. Has the member tried and failed systemic immunosuppressive therapy [e.g., cyclosporine, methotrexate, azathioprine] medically appropriate for Atopic Dermatitis?
□ Yes: Please provide what oral systemic therapy (name) the member has failed.

_____

□ No: Can the member try systemic immunosuppressive therapy [e.g., methotrexate, azathioprine] instead?
□ **Yes**: Please notify the pharmacy of the change and return the form.
□ **No:** Please provide reason why:

_____

**Physician office's signature*_____ Print Name_____**
***Form must be completed and signed by physician or licensed representative from the physician's office**

f. Has the member tried and failed a topical calcineurin inhibitor [tacrolimus (Protopic), pimecrolimus (Elidel)]?
□ Yes: Please provide what calcineurin inhibitor (name) the member has failed.

_____

□ No: Can the member try a calcineurin inhibitor [tacrolimus (Protopic), pimecrolimus (Elidel)] instead?
□ Yes: Please notify the pharmacy of the change and return the form.
□ No: Please provide reason why:_____.
_____

g. Has the member tried and failed any other therapies (pharmacological and/or non-pharmacological) for the diagnosis provided?
□ **Yes**: Please provide what other therapies the member has failed._____
_____
□ **No**

h. Will the member continue to use topical emollients together with Dupixent in problem areas (e.g., face, neck, genitals) to help prevent flares? **Yes or No**

i. For members younger than 18 years of age:

What is the member's current weight? _____lbs or _____kg

j. Will the success of treatment be assessed regularly? **Yes or No**

**Physician office's signature*_____ Print Name_____**
***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

□ **Asthma**

a. Please indicate the severity of the asthma: □ mild □ moderate □ severe

b. Does the member have oral corticosteroid dependent asthma? **Yes or No**
   a. If **Yes**, **Please provide documentation (e.g. office note, pharmacy claims) showing member has oral corticosteroid dependent asthma**
   _____

c. Does the member have asthma with an eosinophilic phenotype? **Yes or No**
   If **Yes**:
   1. Is the member currently receiving high dosed inhaled corticosteroid or on oral corticosteroid? **Yes or No**
   2. What is the blood eosinophil level while on high dosed inhaled corticosteroid or oral corticosteroid? _____***Please submit lab documentation**

d. Has the member experienced ≥2 exacerbations requiring oral corticosteroids within the past 12 months? **Yes or No**

e. Has the member had serious asthma exacerbations requiring hospitalization, mechanical ventilation, or visit to the emergency room or urgent care within past 12 months? **Yes or No**

f. Does the member have a baseline Forced Expiratory Volume (FEV1) that is less than 80% of the predicted after bronchodilator use? **Yes or No**

g. Does the member's controlled asthma get worse when the dose of inhaled or systemic corticosteroids are tapered? **Yes or No**

h. Is the member currently being treated with a medium-high dose inhaled corticosteroid (ICS)? **Yes** or **No**
   - **If yes**: Please provide drug name, strength, directions AND dates filled within the past several months:
     _____
   - **If No**, Can member try a medium-high dose inhaled corticosteroid instead? **Yes** or **No**
     - **If Yes**: Please notify the pharmacy of the change
     - **If No**:
       - Please provide reason why:_____
       - Can the member try a low-dose inhaled corticosteroid instead? **Yes or No**
         - **If yes:** Please notify the pharmacy of the change
         - **If No:** Please provide reason why member cannot use any inhaled corticosteroids**:_____**

i. Is the member currently being treated with a long-acting beta agonist (LABA)? **Yes** or **No**
   - **If Yes**, please provide drug name AND dates filled within the past several months:
     _____
     _____
   - **If No**, can member try a LABA instead? **Yes** or **No**
     I. **If Yes**, please notify the pharmacy of the change
     II. **If No**, please provide reason why: _____

**Physician office's signature*_____ Print Name_____**
***Form must be completed and signed by physician or licensed representative from the physician's office**

j. Is the member currently being treated with a leukotriene receptor antagonist (LTRA)? **Yes** or **No**
- **If Yes**, please provide drug name AND dates filled within the past several months:

  _____

  _____
- **If No**, can member try a LTRA instead? **Yes** or **No**
  I. **If Yes**, please notify the pharmacy of the change
  II. **If No**, please provide reason why: _____

k. Is the member currently being treated with a long-acting muscarinic antagonist (LAMA)? **Yes** or **No**
- **If Yes**, please provide drug name AND dates filled within the past several months:

  _____

  _____
- **If No**, can member try a LAMA instead? **Yes** or **No**
  I. **If Yes**, please notify the pharmacy of the change
  II. **If No**, please provide reason why: _____

l. Is the member currently being treated with any other controller medications? **Yes** or **No**
- **If Yes**, please provide drug name(s) AND dates filled within the past several months:

  _____

  _____

m. What other asthma control therapy [e.g., ICS, LABA, LTRA, LAMA, etc.] will the member be taking together with the requested drug?_____

n. Will the member be using any other biologic drug [e.g., omalizumab (Xolair), Reslizumab (Cinqair), Mepolizumab (Nucala), Benralizumab (Fasenra), or Tezepelumab-ekko (Tezspire)] with Dupixent? **Yes or No**
- **If Yes**, please provide the drug name and diagnosis it is being used to treat:

  _____

□ **Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP)**

a. Is the member's chronic rhinosinusitis confirmed by nasal endoscopy, anterior rhinoscopy, or computed tomography (CT) scanning? Yes or No

b. Does the member have nasal polyps? **Yes or No**

c. Does the member have ongoing symptoms of moderate-severe nasal congestion/ blockage/obstruction? **Yes or No**

d. Does the member have the symptoms such as loss of smell, rhinorrhea (anterior/posterior), etc? **Yes or No**

e. Did the member have an inadequate response to sinonasal surgery? **Yes or No**

f. Is the member a candidate for sinonasal surgery? **Yes or No**

g. Has the member tried an oral corticosteroid?

□ **Yes**:
- Please provide the dates the member tried an oral corticosteroid _____
- Did the member have an inadequate response to oral corticosteroid therapy? **Yes or No**

**Physician office's signature*_____ Print Name_____**

***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

□ **No**: Please let us know the reason why not_____

_____

h. Has the member tried topical intranasal corticosteroids (INCS)?

□ **Yes**:

- Please provide the dates the member tried topical intranasal corticosteroids (INCS)

_____

- Did the member have an inadequate response to topical intranasal corticosteroid (INCS)? **Yes or No**

□ **No**: Can the member try topical intranasal corticosteroids (INCS)?

□ Yes: Please notify the pharmacy of the change and return the form.

□ No: Please provide the clinical reason why a topical intranasal corticosteroids (INCS) cannot be tried.

_____

**i.** Will the member continue standard maintenance therapy (e.g., nasal saline irrigation, intranasal corticosteroids) in combination with Dupilumab (Dupixent)? **Yes or No**

j. Will the member be using any other biologic drugs [e.g., Omalizumab (Xolair) or M epolizumab (Nucala), with Dupixent? **Yes or No**

**If Yes**, please provide the drug name and diagnosis it is being used to treat:

_____

□ **Eosinophilic Esophogitis (EoE)**

a. What is member's current weight? _____lbs or _____kg

b. Has the member tried and failed topical corticosteroid therapy ( e.g. Flovent HFA or Pulmicort Respules) for the diagnosis provided?

□ **Yes**: Please provide what topical therapies (name and dosage form) the member has failed.

_____

□ **No**: Can the member try a topical corticosteroid instead?

□ **Yes**: Please notify the pharmacy of the change and return the form.

□ **No**: Please provide reason why:_____ _____

c. Have other causes of esophageal esophagitis been ruled out (e.g. specific food sensitivities have been ruled out)? **Yes or No**

d. Will the member be using any other biologic drug [e.g., omalizumab (Xolair), Reslizumab (Cinqair), Mepolizumab (Nucala), or Benralizumab (Fasenra)] with Dupixent? **Yes or No**

**If Yes**, please provide the drug name and diagnosis it is being used to treat:

**Physician office's signature*_____ Print Name_____**

***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

□ **Other Diagnosis**: _____

**Physician office's signature*_____ Print Name_____**
***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

**Horizon NJ Health**
**Dupilumab (Dupixent) – Medical Necessity Request**
****Complete page 5 and 6 only for Subsequent Requests****

## Diagnosis

□ **Atopic Dermatitis (Eczema)**

1. Has the member responded to treatment as demonstrated by an improvement and/or stabilization (eg, results) compared to baseline? **Yes or No**

2. Will the member continue the use of topical emollients together with Dupixent in problem areas (e.g., face, neck, genitals) to prevent flares? **Yes or No**

3. What is the member's current weight _____ lb or _____ kg Date: _____

□ **Asthma**

1. Has the member responded to therapy compared to baseline? **Yes or No**
   a. **If Yes**, how has the member responded to therapy compared to baseline? (check <u>all</u> that apply):
      □ Reduction of the number of hospitalizations, need for mechanical ventilation, or visits to urgent care or emergency room due to asthma exacerbations
      □ Reduction in dose inhaled/oral corticosteroids required to control the patient's asthma
      □ Reduction in use of rescue medication
      □ Increase in pulmonary function tests (e.g., Forced Expiratory Volume from baseline)
      □ Decrease in symptoms and asthma exacerbations
      □ None of the above
      **- If None of the above**, please provide any additional clinical information pertaining to the request.

      _____

      _____

   b. **If No**, please provide reason to continue prescribing the requested drug:
      _____

2. Is the member currently being treated and has been compliant with standard asthma control therapy [e.g., inhaled corticosteroids, long-acting beta-2 agonist (LABA), leukotriene receptor antagonist (LTRA), long-acting muscarinic antagonist (LAMA)] for the past 90 days? **Yes or No**
   **If No**, please provide reason why:
   _____

3. What other asthma control therapy [e.g., ICS, LABA, LTRA, LAMA, etc.] will the member be taking together with the requested drug?
   _____

**Physician office's signature*_____ Print Name_____**
***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

4. Will the member be using any other biologic drug [e.g., omalizumab (Xolair), Reslizumab (Cinqair), Mepolizumab (Nucala), Benralizumab (Fasenra)], or Tezepelumab-ekko (Tezspire)] with Dupixent? **Yes or No**
   **If Yes**, please provide drug name and diagnosis it is being used to treat:
   _____

□ **Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP)**

1. How has the member responded to therapy?
   □ Reduction of systemic corticosteroid use
   □ Decrease in nasal congestion/obstruction
   □ Improvement in endoscopic nasal polyps score
   □ Decrease in Lund-MacKay (LMK) sinus computed tomography (CT) scan score
   □ Improvement in loss of smell
   □ Decreased sino-nasal symptoms
   □ None of the above
   **- If None of the above**, please provide any additional clinical information pertaining to the request.
   _____

2. Will the member continue standard maintenance therapy (e.g., nasal saline irrigation, intranasal corticosteroids) in combination with Dupilumab (Dupixent)? **Yes or No**

□ **Eosinophillic Esophagitis (EoE)**

1. Has the member responded to treatment as demonstrated by an improvement and/or stabilization (eg, results) compared to baseline? **Yes or No**

3. Will the member be using any other biologic drug [e.g., Omalizumab (Xolair), Reslizumab (Cinqair), Mepolizumab (Nucala), Benralizumab (Fasenra)] with Dupixent? **Yes or No**
   a. **If Yes**, please provide the drug name and diagnosis it is being used to treat:

   _____

□ **Other Diagnosis**: _____

**Physician office's signature*_____ Print Name_____**
***Form must be completed and signed by physician or licensed representative from the physician's office**