SoonerCare
Oklahoma Health Care Authority

State of Oklahoma SoonerCare
Dupixent® (Dupilumab) Prior Authorization Form

Member Name:____________________ Date of Birth:______________ Member ID#:_________________

Drug Information

Pharmacy billing (NDC:________________________) Fill Date:________________________________

Dose:___________________________________ Regimen:___________________________________

Billing Provider Information

Provider NPI: __________________________ Provider Name:_________________________________

Provider Phone:_________________________ Provider Fax:_________________________________

Prescriber Information

Prescriber NPI:______________________ Prescriber Name:_____________________________________

Prescriber Phone:_________________ Prescriber Fax:_________________ Specialty:______________

Clinical Information

Page 1 of 2—Please complete and return all pages. *Failure to complete all pages will result in processing delays.*

For Initial Authorization (Initial approval will be for the duration of 6 months):

1. Please indicate diagnosis and information:
   - ❑ **Moderate-to-Severe Eosinophilic Phenotype Asthma**
   - ❑ **Oral Corticosteroid Dependent Asthma**

   A. Will this medication be used as add-on maintenance treatment? Yes___ No___
      i. If yes, please indicate member's daily medications and dose prescribed for treatment of this diagnosis:
      Drug/Dose:_______________________ Drug/Dose:______________________________

   B. Baseline blood eosinophil count: __________ Date Determined: ________________________

   C. Does member require daily systemic corticosteroids despite compliant use of high-dose inhaled corticosteroid (ICS) plus at least one additional controller medication? Yes___ No___
      i. If no, please list number and dates of exacerbations requiring systemic corticosteroids within last 12 months: Number: _______ Dates of exacerbations: ________________

   D. Has the member been evaluated by an allergist, pulmonologist, or pulmonary specialist within the last twelve months (or an advanced care practitioner with a supervising physician who is an allergist, pulmonologist, or pulmonary specialist)? Yes___ No___
      If yes, please include name of specialist: ______________________________________

   E. Please check all that apply:
      - ❑ Member has failed a high-dose ICS ($\geq$ 880 mcg/day fluticasone propionate or equivalent daily dose or $\geq$ 440 mcg/day in ages 12 to 17) used compliantly for at least the past 12 months (for ICS/LABA combination products, the highest approved dose meets this criteria)
        - Drug/Dose: ____
      - ❑ Member has failed at least one other asthma controller medication used in addition to the high-dose ICS compliantly for at least the past three months
        - Drug/Dose: ____

Please complete and return all pages. *Failure to complete all pages will result in processing delays.*

Please do not send in chart notes. Specific information will be requested if necessary.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*

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Page 2 of 2—Please complete and return all pages.** ***Failure to complete all pages will result in processing delays.*

1. Please indicate diagnosis and information, continued:
   F. Has the member has been counseled on proper administration and storage of Dupixent®?
   Yes____ No____

❑ **Other, please list:____**

For Continued Authorization:

1. Is member compliant with therapy? Yes___ No___

Compliance with all of the prior authorization criteria is a condition for payment for this drug by SoonerCare. All information must be provided and SoonerCare may verify through further requested documentation. The member's drug history will be reviewed prior to approval.

Prescriber Signature:_________________________________ Date:__________________________
(By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.)
Please do not send in chart notes. Specific information/documentation will be requested if necessary.

Please complete and return all pages. ***Failure to complete all pages will result in processing delays.***

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