

Member Name: _____ Date of Birth: _____ Member ID#: _____

Drug Information

Pharmacy billing (NDC: _____) Fill Date: _____
Dose: _____ Regimen: _____

Billing Provider Information

Pharmacy NPI: _____ Pharmacy Name: _____
Pharmacy Phone: _____ Pharmacy Fax: _____

Prescriber Information

Prescriber NPI: _____ Prescriber Name: _____
Prescriber Phone: _____ Prescriber Fax: _____ Specialty: _____

Clinical Information

For Initial Authorization:

1. Please indicate diagnosis:
 - Moderate-to-Severe Eosinophilic Phenotype Asthma
 - Oral Corticosteroid-Dependent Asthma
 - Moderate-to-Severe Atopic Dermatitis
 - Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP)
 - Eosinophilic Esophagitis (EoE)
 - Prurigo Nodularis (PN)
 - Other, please list: _____
 - A. Has the member been counseled on proper administration and storage of Dupixent®? Yes ___ No ___
 - B. Has the member been evaluated by an allergist, gastroenterologist, dermatologist, immunologist, otolaryngologist, pulmonologist, pulmonary specialist within the last 12 months (or an advanced care practitioner with a supervising physician who is one of these specialties)? Yes ___ No ___
 - i. If yes, please include name of specialist: _____ Specialty: _____
 - C. Will the member be using Dupixent® concurrently with other biologic medications? Yes ___ No ___
 - i. If yes, please provide patient-specific information to support the concurrent use of both medications: _____
 - D. What is the member's weight? _____
2. If diagnosis is **Moderate-to-Severe Eosinophilic Phenotype Asthma or Oral Corticosteroid-Dependent Asthma**, please provide the following (*Initial approvals will be for the duration of 6 months*):
 - 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. Please check all that apply:
 - Member has failed a medium to high-dose ICS used compliantly within the last 3-6 consecutive months.
- Drug/Dose: _____
 - Member has failed at least 1 other asthma controller medication used in addition to the medium to high-dose ICS compliantly for at least the past 3 months.
- Drug/Dose: _____

<p><u>PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:</u> 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</p>	<p style="text-align: center;"><u>CONFIDENTIALITY NOTICE</u></p> <p><i>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.</i></p>
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3. If diagnosis is **Moderate-to-Severe Atopic Dermatitis**, please provide the following (*Initial approvals will be for the duration of 16 weeks*):
 - A. Is member inadequately controlled with topical prescription therapies? Yes ___ No ___
 - B. Has the member failed 1 medium potency to very-high potency Tier-1 topical corticosteroid?

Yes ___ No ___

 - i. If yes, please provide the medication and duration of treatment:
 - a. Drug: _____ Date of trial: _____
 - b. Was the trial at least 2 weeks in duration? Yes ___ No ___
 - ii. If no, is there a contraindication or documented intolerance to medium potency to very-high potency Tier-1 topical corticosteroids? Yes ___ No ___
 - a. If yes, please describe: _____
 - C. Has the member failed 1 topical calcineurin inhibitor [e.g., Elidel® (pimecrolimus), Protopic® (tacrolimus)]?

Yes ___ No ___

 - i. If yes, please provide the medication and duration of treatment:
 - a. Drug: _____ Date of trial: _____
 - b. Was the trial at least 2 weeks in duration? Yes ___ No ___
 - ii. If no, is there a contraindication or documented intolerance to topical calcineurin inhibitors?

Yes ___ No ___

 - a. If yes, please describe: _____

4. If diagnosis is **Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP)**, please provide the following (*Initial approvals will be for the duration of 6 months*):
 - A. Will Dupixent® be used as add-on maintenance treatment for inadequately controlled CRSwNP?

Yes ___ No ___
 - B. Does the member have a trial with intranasal corticosteroid that resulted in failure (or have a contraindication or documented intolerance)? Yes ___ No ___
 - i. If yes, please provide the medication used and dates of use: _____
 - C. Has the member required prior sino-nasal surgery? Yes ___ No ___
 - D. Has the member been treated with systemic corticosteroids for CRSwNP in the past 2 years (or have a contraindication or documented intolerance)? Yes ___ No ___
 - E. Does the member have symptoms of chronic rhinosinusitis (e.g., facial pain/pressure, reduction or loss of smell, nasal blockade/obstruction/congestion, nasal discharge) for 12 weeks or longer despite attempts at medical management? Yes ___ No ___
 - F. Does the member have evidence of nasal polyposis by direct examination, sinus CT scan, or endoscopy?

Yes ___ No ___
 - G. Will the member continue to receive intranasal corticosteroid therapy? Yes ___ No ___
 - i. If no, does the member have a contraindication to intranasal corticosteroid therapy? Yes ___ No ___
 1. If yes, please provide the member's contraindication: _____

5. If diagnosis is **Eosinophilic Esophagitis (EoE)**, please provide the following (*Initial approvals will be for the duration of 6 months*):
 - A. Does the member have 2 or more episodes of dysphagia per week? Yes ___ No ___
 - B. Does the member have ≥ 15 intraepithelial eosinophils per high-power field (eol/hpf)? Yes ___ No ___

(continued on next page)

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- C. Has the member failed 1 high-dose proton pump inhibitor?
 Yes ___ No ___
 i. If yes, please provide the medication and duration of treatment:
 a. Drug: _____ Date of trial: _____
 b. Was the trial at least 8 weeks in duration? Yes ___ No ___
 ii. If no, is there a contraindication or documented intolerance to high-dose proton pump inhibitors?
 Yes ___ No ___
 a. If yes, please describe: _____
- D. Has the member failed 1 swallowed inhaled respiratory corticosteroid (e.g. budesonide)?
 Yes ___ No ___
 i. If yes, please provide the medication and duration of treatment:
 a. Drug: _____ Date of trial: _____
 b. Was the trial at least 8 weeks in duration? Yes ___ No ___
 ii. If no, is there a contraindication or documented intolerance to swallowed inhaled respiratory corticosteroids? Yes ___ No ___
 a. If yes, please describe: _____
6. If diagnosis is **Prurigo Nodularis (PN)**, please provide the following (*Initial approvals will be for the duration of 6 months*):
- A. Has the member had a diagnosis of PN for at least 3 months? Yes ___ No ___
 B. Does the member have a Worst-Itch Numeric Rating Scale (WI-NRS) score of ≥ 7 ? Yes ___ No ___
 C. Does the member have ≥ 20 PN lesions? Yes ___ No ___
 D. Has the prescriber ruled out all other causes of pruritis? Yes ___ No ___
 E. Has the member failed 1 medium potency to very-high potency Tier-1 topical corticosteroid?
 Yes ___ No ___
 i. If yes, please provide the medication and duration of treatment:
 a. Drug: _____ Date of trial: _____
 b. Was the trial at least 2 weeks in duration? Yes ___ No ___
 ii. If no, is there a contraindication or documented intolerance to medium potency to very-high potency Tier-1 topical corticosteroids? Yes ___ No ___
 a. If yes, please describe: _____
- F. Has the member failed 1 topical calcineurin inhibitor [e.g., Elidel® (pimecrolimus), Protopic® (tacrolimus)]?
 Yes ___ No ___
 i. If yes, please provide the medication and duration of treatment:
 a. Drug: _____ Date of trial: _____
 b. Was the trial at least 2 weeks in duration? Yes ___ No ___
 ii. If no, is there a contraindication or documented intolerance to topical calcineurin inhibitors?
 Yes ___ No ___
 a. If yes, please describe: _____

For Continued Authorization:

1. Is member compliant with therapy? Yes ___ No ___
2. Is member responding well to 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.

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