

# OPTIMA FAMILY CARE MEDALLION 4.0

## PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST\*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay the authorization process.

**Drug Requested:** Dupixent® (dupilumab) (Non-Preferred) (MEDICAID)

**Drug Information:** Complete all information below or authorization process will be delayed.

Drug Form: \_\_\_\_\_ Strength: \_\_\_\_\_

Dosing Schedule: \_\_\_\_\_ Length of Therapy: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD Code, if applicable: \_\_\_\_\_

**Quantity Limit:** 2 prefilled syringes for the initial dose; then 1 single-dose syringe every 14 days

**Length of Authorization:** 6 months

**Clinical Criteria:** All boxes below **must** be checked for approval. Chart notes documenting improvement in the patient's condition **MUST** be attached to ensure authorization will NOT be delayed.

### Initial Authorization Approval – 6 MONTHS

- Patient is ≥18 years old  
**AND**
- Patient has a diagnosis of **moderate to severe** atopic dermatitis ≥ 1 of the following:
  - Involvement of at least 10% of body surface area (BSA);  
**OR**
  - Scoring Atopic Dermatitis (SCORAD) score of 20 or more;  
**OR**
  - Investigator's Global Assessment (IGA) with a score ≥ 3;  
**OR**
  - Eczema Area and Severity Index (EASI) score of ≥ 16;  
**OR**
  - Incapacitation due to AD lesion location (e.g., head and neck, palms, soles, or genitalia);  
**AND**
- Prior documented trial and failure (or contraindication) of 1 topical corticosteroids of medium to high potency (e.g., mometasone, fluocinolone) and 1 topical calcineurin inhibitors (tacrolimus or pimecrolimus);  
**AND**
- Inadequate response to a 3-month minimum trial of at least 1 immunosuppressive systemic agent (e.g., cyclosporine, azathioprine, methotrexate, mycophenolate mofetil, etc.);  
**AND**
- Inadequate response (or is not a candidate) to a 3-month minimum trial of phototherapy (e.g., psoralens with UVA light [PUVA], UVB, etc.) provided member has reasonable access to photo treatment;  
**AND**
- Is not pregnant;  
**AND**
- Is not concurrently receiving a live vaccine

(continued on next page)

**Renewal Criteria/Authorization:**

**All boxes *must* be checked for approval. Chart notes documenting improvement in the patient's condition *MUST* be attached.**

- Patient must continue to meet above criteria;  
**AND**
- Patient does not have documented toxicity from the agent (e.g., hypersensitivity, conjunctivitis, keratitis, immunogenicity);  
**AND**
- Had documented response compared to baseline as measured by measures used to qualify moderate to severe AD at baseline (e.g., pruritus, BSA involvement, EASI, IGA, SCORAD).

***Medication being provided by a Specialty Pharmacy - PropriumRx***

***\*Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.\****

***\*Previous therapies will be verified through pharmacy paid claims or submitted chart notes.\****

Patient Name: \_\_\_\_\_

Member Optima #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Prescriber Name: \_\_\_\_\_

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Office Contact Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

DEA OR NPI #: \_\_\_\_\_

REVISED/UPDATED: 7/1/2018