OPTIMA HEALTH COMMUNITY CARE
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 1-800-319-5003. 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 information below. If incomplete, 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.

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: ~~6/29/2017; 7/11/2017;~~ **8/28/2017**