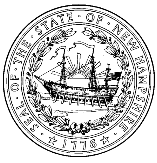

New Hampshire Medicaid Fee-for-Service (FFS) Program
Prior Authorization/Non-Preferred Drug Approval Form

Dupixent® (dupilumab)

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

FIRST NAME:

MEDICAID ID NUMBER:

DATE OF BIRTH: – –

GENDER: ☐ Male ☐ Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

FIRST NAME:

SPECIALTY:

NPI NUMBER:

PHONE NUMBER: – –

FAX NUMBER: – –

SECTION III: CLINICAL HISTORY

1. Does the patient have a diagnosis of moderate or severe persistent asthma? ☐ Yes ☐ No
   If ***yes***, please answer questions **6–12.**
2. Does the patient have a diagnosis of moderate to severe atopic dermatitis? ☐ Yes ☐ No
   If ***yes***, please answer questions **13–17.**
3. Does the patient have a diagnosis of chronic rhinosinusitis with nasal polyposis? ☐ Yes ☐ No
   If ***yes***, please answer questions **18–22.**
4. Does the patient have a diagnosis of eosinophilic esophagitis? ☐ Yes ☐ No
   If ***yes***, please answer questions **23–24.**
5. Does the patient have a diagnosis of prurigo nodularis? ☐ Yes ☐ No
   If ***yes***, please answer questions **25–26.**
6. Is a pulmonologist, allergist, or immunologist prescribing this medication, OR has one of these specialists been consulted in this case? ☐ Yes ☐ No

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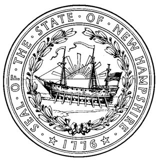


New Hampshire Medicaid Fee-for-Service (FFS) Program
Prior Authorization/Non-Preferred Drug Approval Form

Dupixent® (dupilumab)

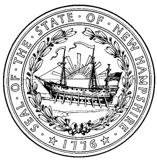
PATIENT LAST NAME: | | | | | | | | | | | | |

PATIENT FIRST NAME: | | | | | | | | | | | | |

SECTION III: CLINICAL HISTORY *(continued)*

7. Is the patient symptomatic despite taking medium-to-high dose of inhaled corticosteroids or oral steroids in combination with either a long-acting beta$_2$ agonist, a leukotriene modifier, or theophylline? ☐ Yes ☐ No
   a. If ***yes***, indicate which medication(s) patient is currently taking: ☐ LABA: ____________
   ☐ Leukotriene receptor agonist: ____________ ☐ Theophylline
8. Has the patient's allergy been confirmed by skin testing or *in vitro* activity to the allergen? ☐ Yes ☐ No
9. Is the patient's IgE result > 30 IU/mL and ≤ 700 IU/mL? ____________ IU/mL ☐ Yes ☐ No
10. Is the patient poorly compliant on the current asthma treatment plan? ☐ Yes ☐ No
11. Is the patient an active smoker? ☐ Yes ☐ No
12. Is this patient being treated exclusively for a peanut allergy? (move to section IV) ☐ Yes ☐ No
13. Is a dermatologist, immunologist, or allergist prescribing this medication, OR has one been consulted in this case? ☐ Yes ☐ No
14. What is the patient's age? ____________
15. Has there been a failure, contraindication, or intolerance to topical corticosteroid therapy? ☐ Yes ☐ No
    a. If ***yes***, describe treatment failure, contraindication, or intolerance and provide date:
    ____
16. Has the patient been treated with topical pimecrolimus or tacrolimus in the past? ☐ Yes ☐ No
    a. If ***yes***, provide drug name and duration of therapy:
    ____
17. Has the patient been treated with at least one month of therapy with topical Eucrisa® in the past? (Go to Section IV.) ☐ Yes ☐ No
18. Is an ear, nose, and throat (ENT) specialist prescribing this medication, OR has one been consulted in this case? ☐ Yes ☐ No
19. Is the patient ≥ 18 years old? ☐ Yes ☐ No
20. Will Dupixent® (dupilumab) will be used as an add-on maintenance treatment? ☐ Yes ☐ No
21. Has patient had prior sino-nasal surgery OR had treatment with, were ineligible to receive, or were intolerant to systemic corticosteroids within the past 2 years? ☐ Yes ☐ No

(Form continued on next page.)



New Hampshire Medicaid Fee-for-Service (FFS) Program
Prior Authorization/Non-Preferred Drug Approval Form
Dupixent® (dupilumab)

PATIENT LAST NAME: **PATIENT FIRST NAME:**

SECTION III: CLINICAL HISTORY *(continued)*

22. Has patient had a trial and failure of intranasal steroids? ☐ Yes ☐ No
    a. If ***yes***, provide drug name and duration of therapy:
23. Is a gastroenterologist, immunologist, or allergist prescribing this medication, OR has one been consulted in this case? ☐ Yes ☐ No
24. Is the patient ≥ 12 years of age AND ≥ 40 kg? ☐ Yes ☐ No
25. Is a dermatologist, immunologist, or allergist prescribing this medication, OR has one been consulted in this case? ☐ Yes ☐ No
26. Is the patient ≥ 18 years old? ☐ Yes ☐ No

Provide any additional information that would help in the decision-making process. If additional space is needed, please use another page.

SECTION IV: NON-PREFERRED DRUG APPROVAL CRITERIA

Chapter 188 of the laws of 2004 requires that Medicaid only cover non-preferred drugs upon a finding of medical necessity by the prescribing physician. Chapter 188 requires that you base your determination of medical necessity on the following criteria.

☐ Allergic reaction. **Describe reaction:**

☐ Drug-to-drug interaction. **Describe reaction:**

☐ Previous episode of an unacceptable side effect or therapeutic failure. **Provide clinical information:**

(Form continued on next page.)

New Hampshire Medicaid Fee-for-Service (FFS) Program
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Dupixent® (dupilumab)

PATIENT LAST NAME:	PATIENT FIRST NAME:

☐ Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to a preferred drug. **Provide clinical information:**

☐ Age-specific indications. **Provide patient age and explain:**

☐ Unique clinical indication supported by FDA approval or peer-reviewed literature. **Explain and provide a reference:**

☐ Unacceptable clinical risk associated with therapeutic change. **Please explain:**

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PRESCRIBER'S SIGNATURE: ____ **DATE**: _____________________