



# New Hampshire Medicaid Fee-for-Service Program Prior Authorization Drug Approval Form

Dupixent® (dupilumab)

DATE OF MEDICATION REQUEST:     /     /

## SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

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FIRST NAME:

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MEDICAID ID NUMBER:

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DATE OF BIRTH:

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GENDER:    Male    Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

## SECTION II: PRESCRIBER INFORMATION

LAST NAME:

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FIRST NAME:

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SPECIALTY:

NPI NUMBER:

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PHONE NUMBER:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

FAX NUMBER:

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## SECTION III: CLINICAL HISTORY

- Does the patient have a diagnosis of moderate or severe persistent asthma?      Yes    No  
If **Yes**, please answer questions **4–10**
- Does the patient have a diagnosis of moderate to severe atopic dermatitis?      Yes    No  
If **Yes**, please answer questions **11–14**
- Does the patient have a diagnosis of chronic rhinosinusitis with nasal polyposis?      Yes    No  
If **Yes**, please answer questions **15–19**
- Is a pulmonologist, allergist, or immunologist prescribing this medication, OR has one of these specialists been consulted in this case?      Yes    No

(Form continued on next page.)



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Dupixent® (dupilumab)

DATE OF MEDICATION REQUEST:     /     /

PATIENT LAST NAME:

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PATIENT FIRST NAME:

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### SECTION III: CLINICAL HISTORY (CONTINUED)

5. Is the patient symptomatic despite taking medium-to-high dose of inhaled corticosteroids or oral steroids in combination with either a long-acting beta<sub>2</sub> agonist, a leukotriene modifier, or theophylline?  Yes  No
- a. If Yes, please indicate which medication(s) patient is currently taking:  LABA: \_\_\_\_\_  
 Leukotriene receptor agonist: \_\_\_\_\_  Theophylline
6. Has the patient's allergy been confirmed by skin testing or *in vitro* activity to the allergen?  Yes  No
7. Is the patient's IgE result > 30 IU/mL and ≤ 700 IU/mL? \_\_\_\_\_ IU/mL  Yes  No
8. Is the patient poorly compliant on the current asthma treatment plan?  Yes  No
9. Is the patient an active smoker?  Yes  No
10. Is this patient being treated exclusively for a peanut allergy?  Yes  No
11. Is a dermatologist prescribing this medication, OR has one been consulted in this case?  Yes  No
12. What is the patient's age? \_\_\_\_\_
13. Has there been a failure, contraindication, or intolerance to topical corticosteroid therapy?  Yes  No
- a. If YES, please describe treatment failure, contraindication, or intolerance and provide date:  
 \_\_\_\_\_
- 
14. Has the patient been treated with a topical immunomodulator in the past?  Yes  No
- a. If YES, please provide drug name and duration of therapy:  
 \_\_\_\_\_
- 
15. Is an ear, nose and throat (ENT) specialist prescribing this medication, OR has one been consulted in this case?  Yes  No
16. Is the patient ≥ 18 years old?  Yes  No
17. Will Dupixent® (dupilumab) will be used as an add-on maintenance treatment?  Yes  No
18. 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.)



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Drug Approval Form**

Dupixent® (dupilumab)

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PATIENT LAST NAME:

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PATIENT FIRST NAME:

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**SECTION III: CLINICAL HISTORY (CONTINUED)**

19. Has patient had a trial and failure of intranasal steroids?  Yes  No
- a. If YES, please provide drug name and duration of therapy:

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

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**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:** \_\_\_\_\_