1. What is the prescriber’s specialty? □ Allergy □ Pulmonology □ Dermatology □ Other: __________________________

**Diagnosis**

□ Atopic Dermatitis (Eczema)
  a. Please indicate the severity of atopic dermatitis: □ mild □ moderate □ severe
  
  b. Is at least 10% of the member’s body surface area affected? **Yes or No**
  
  c. Has the member tried and failed topical therapy for the diagnosis provided?
      □ Yes: Please provide what topical therapies the member has failed. __________________________

      □ No: Can the member try a topical corticosteroid (e.g. mometasone ointment, betamethasone dipropionate ointment) instead?
          □ Yes: Please notify the pharmacy of the change and return the form.
          □ No: Please provide the clinical reason why a topical corticosteroid cannot be tried.

          __________________________

      d. Has the member tried and failed any other therapies (pharmacological and/or non-pharmacological) for the diagnosis provided?
         □ Yes: Please provide what other therapies the member has failed. __________________________

         □ No

      e. Will the member use topical emollients together with Dupixent to help prevent flares? **Yes or No**
Member Name: ___________________________  Member ID: ________________  Member DOB: ________________
Drug Name: _____________________________  Strength: ___________  Directions: _____________________________
Physician Name: __________________________  Physician Phone #: ___________________________  Specialty: ___________________________
Physician Fax #: _________________________  Pharmacy Name: _____________________________  Pharmacy Phone: ______________________

□ Asthma
a. Please indicate the severity of the asthma: □ mild □ moderate □ severe
b. Does the member have oral corticosteroid dependent asthma? Yes or No
   a. If Yes, what is the name of the steroid that the member is taking and what is the mg/day dose?
   b. Please provide the date(s) the member received steroid therapy

c. Does the member have asthma with an eosinophilic phenotype? Yes or No
   a. If Yes:
      1. What is the blood eosinophil level? (please also submit lab documentation from within the past 3 months)
      2. Does the member require continued use of an inhaled corticosteroid AND another controller therapy (e.g., long-acting beta-agonist, leukotriene modifier)? Yes or No
         1. If Yes, please provide the name(s) of the inhaled corticosteroid and/or controller, the dose received, and the dates the member received the medication(s)

d. Has the member experienced ≥2 exacerbations within the last 12 months despite adherent use of controller therapy [i.e., medium to high dose inhaled corticosteroid (ICS) plus either a long acting beta-2 agonist (LABA) or leukotriene modifier (LTRA)]? Yes or No
   1. If Yes, please provide the name(s) of the inhaled corticosteroid and/or controller, the dose received, and the dates the member received the medication(s)

e. Has the member required any of the following (please indicate if any) within the past 12 months?
   □ Oral/systemic corticosteroid treatment (or increase in dose if already on oral corticosteroid)
   □ Urgent care visit or hospital admission
   □ None of the above

f. Will the member continue to use baseline therapy with Dupixent? Yes or No
   1. If Yes, please provide the name(s) of the baseline therapy, the dose received, and the dates the member received the medication(s)


g. Is Dupixent being requested as maintenance therapy? Yes or No

h. Is Dupixent being used for the relief of acute bronchospasm or status asthmaticus? Yes or No

Physician office's signature*  Print Name

*Form must be completed and signed by physician or licensed representative from the physician’s office

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i. Will the member be using any other biologic drug [omalizumab (Xolair), Reslizumab (Cinqair), Mepolizumab (Nucala), or Benralizumab (Fasenra)] with Dupixent? **Yes or No**

a. If **Yes**, please let us know what indication omalizumab (Xolair), Reslizumab (Cinqair), Mepolizumab (Nucala), or Benralizumab (Fasenra) is being used concomitantly for.

□ Other: ____________________________________________

*Form must be completed and signed by physician or licensed representative from the physician’s office*
Horizon NJ Health

_Dupilumab (Dupixent) – Medical Necessity Request_

**Complete page 4 only for Subsequent Requests**

### Diagnosis

**Atopic Dermatitis (Eczema)**

1. Has the member experienced an improvement or stabilization of disease compared to baseline?  
   - Yes: Please specify:
     - Reduction in flares
     - Decreased or stabilization of body surface area affected
     - Reduction in symptoms (e.g. pruritis, oozing, dry skin, crusting)
     - Other ____________________________
   - No

2. Will the member use topical emollients together with Dupixent to prevent flares?  
   - Yes or No

**Asthma**

1. Has the member demonstrated adherence to baseline therapy?  
   - Yes or No

2. Does the prescriber plan to continue using baseline therapy with Dupixent?  
   - Yes or No
   1. If Yes, please provide the name(s) of the baseline therapy, the dose received, and the dates the member received the medication(s)

3. Has the member responded to therapy?  
   - Yes or No
   If Yes, the member responded to therapy by:
     - Reduction of asthma exacerbations
     - Reduction in asthma maintenance medications or daily maintenance oral corticosteroid dose
     - Increase in pulmonary functions tests
     - None of the above
     - Other: __________________________

4. Will the member be using any other biologic drug [omalizumab (Xolair), Reslizumab (Cinqair), Mepolizumab (Nucala), or Benralizumab (Fasenra)] with Dupixent?  
   - Yes or No
   b. If Yes, please let us know what indication omalizumab (Xolair), Reslizumab (Cinqair), Mepolizumab (Nucala), or Benralizumab (Fasenra) is being used concomitantly for.

   - Other: __________________________

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Physician office’s signature*  
Print Name

*Form must be completed and signed by physician or licensed representative from the physician’s office