Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Horizon NJ Health

Dupilumab (Dupixent) – Medical Necessity Request

*****Complete page 1,2 and 3 only for New/Initial Requests*****

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**

Physician office's signature*_____ Print Name_____

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

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 receptor)? **Yes or No**

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**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

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: _____

Physician office's signature*_____ Print Name_____
***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

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 to 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: _____

Physician office's signature*_____ Print Name_____

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