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, 3 and 4 only for New/Initial Requests****

1. What is the prescriber's specialty managing the medication?
□ Allergy □ Pulmonology □ Dermatology □ Otolaryngologist □ 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. Does the member have clinically difficult to treat areas (e.g., face, neck, genital) that interfere with quality of life? **Yes** or **No**

a. If **Yes:** What are the affected areas?

_____

d. Has the member tried and failed topical corticosteroid therapy for the diagnosis provided?
□ **Yes**: Please provide what topical therapies (name, strength, dosage form, and dates tried) the member has failed.

_____

□ **No**: Can the member try a medium to very high potency topical corticosteroid (e.g. mometasone ointment 0.1%, betamethasone dipropionate ointment 0.05%, etc) 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.

_____

e. Has the member tried and failed systemic immunosuppressive therapy [e.g., cyclosporine, methotrexate, azathioprine] medically appropriate for Atopic Dermatitis?
□ Yes: Please provide what oral systemic therapy (nameand dates tried) the member has failed.

_____

□ No: Can the member try systemic immunosuppressive therapy [e.g., methotrexate, azathioprine] instead?
□ **Yes**: Please notify the pharmacy of the change and return the form.
□ **No:** Please provide the clinical reason why an oral systemic therapy cannot be tried.

_____

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

f. Has the member tried and failed a topical calcineurin inhibitor [tacrolimus (Protopic), pimecrolimus (Elidel)]?
□ Yes: Please provide what calcineurin inhibitor (name and dates tried) the member has failed.

_____

□ No: Can the member try a calcineurin inhibitor [tacrolimus (Protopic), pimecrolimus (Elidel)] instead?
□ Yes: Please notify the pharmacy of the change and return the form.
□ No: Please provide the clinical reason why a calcineurin inhibitor cannot be tried.

_____

g. 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**

h. Will the member continue to use topical emollients together with Dupixent in problem areas (e.g., face, neck, genitals) to help prevent flares? **Yes or No**

i. For members younger than 18 years of age:

What is the member's current weight? _____lbs or _____kg

j. Will the success of treatment be assessed regularly, including 16 weeks after treatment, and with Dermatology Life Quality Index (DLQI)? **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**, ***Please provide documentation (e.g. office note, pharmacy claims) showing member has oral corticosteroid dependent asthma***

      _____

c. Does the member have asthma with an eosinophilic phenotype? **Yes or No**
   If **Yes**:
   1. Is the member currently receiving high dosed inhaled corticosteroid or on oral corticosteroid? **Yes or No**
   2. What is the blood eosinophil level while on high dosed inhaled corticosteroid or oral corticosteroid? _____***Please submit lab documentation***

d. Has the member experienced ≥2 exacerbations requiring oral corticosteroids within the past 12 months? **Yes or No**

e. Has the member had serious asthma exacerbations requiring hospitalization, mechanical ventilation, or visit to the emergency room or urgent care within past 12 months? **Yes or No**

f. Does the member have a baseline Forced Expiratory Volume (FEV1) that is less than 80% of the predicted after bronchodilator use? **Yes or No**

g. Does the member's controlled asthma get worse when the dose of inhaled or systemic corticosteroids are tapered? **Yes or No**

h. Has member received a medium-high dose inhaled corticosteroid? **Yes** or **No**
   - **If yes**: Please provide drug name and strength _____
     Directions_____
     Dates filled within the past several months_____
     _____
   - **If No**, Can member try a medium-high dose inhaled corticosteroid instead? **Yes** or **No**
     - **If Yes**: Please notify the pharmacy of the change
     - **If No**:
       - Please provide clinical reason_____
       - Can the member try a low-dose inhaled corticosteroid instead? **Yes or No**
         - **If yes:** Please notify the pharmacy of the change
         - **If No:** Please provide clinical reason why member cannot use any inhaled corticosteroids _____

**i.** Has member received long-acting beta agonist (LABA) therapy? **Yes** or **No**
   - **If Yes**, please provide drug name_____
     - Dates filled within the past several months _____
   - **If No,** Can member try LABA therapy instead? **Yes** or **No**
     - **If Yes**: Please notify the pharmacy of the change
     - **If No**, please provide clinical reason_____

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

j. Has member received Leukotriene modifier (e.g., montelukast or zafirlukast)? **Yes** or **No**
   - **If Yes**, please provide drug name_____
     - Dates filled within the past several months _____
   - **If No**, Can member try Leukotriene modifier therapy instead? **Yes or No**
     - **If yes**: Please notify the pharmacy of the change
     - **If No,** please provide clinical reason_____

k. Has member received Long-acting muscarinic antagonist (LAMA)? **Yes** or **No**
   - **If Yes**, please provide drug name_____
     - Dates filled within the past several months _____
   - **If No**, Can member try LAMA therapy instead? **Yes** or **No**
     - **If yes**: Please notify the pharmacy of the change
     - **If No,** please provide clinical reason_____

l. Has member received Theophylline? **Yes or No**
   - **If yes**, please provide
     - Dates filled within the past several months _____
   - **If No**, Can member try Theophylline therapy instead? **Yes** or **No**
     - **If yes**: Please notify the pharmacy of the change
     - **If No**, please provide clinical reason_____

m. Will the member continue to use standard asthma control therapy [e.g., inhaled corticosteroids (ICS), long-acting beta-2-agonist (LABA), leukotriene receptor antagonist (LTRA), theophylline] with Dupixent? **Yes or No**
   - **If Yes,** please provide the name(s) of the standard asthma control therapy the member will be receiving: _____

n. Will the member be using any other biologic drug [e.g., omalizumab (Xolair), Reslizumab (Cinqair), Mepolizumab (Nucala), Benralizumab (Fasenra)] with Dupixent? **Yes or No**
   a. **If Yes**, please provide the drug name and diagnosis it is being used to treat: _____

**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: _____

□ **Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP)**

a. Is the member's chronic rhinosinusitis confirmed by nasal endoscopy, anterior rhinoscopy, or computed tomography (CT) scanning? **Yes or No**

b. Does the member have nasal polyps? **Yes or No**

c. Does the member have ongoing symptoms of moderate-severe nasal congestion/ blockage/obstruction? **Yes or No**

d. Does the member have the symptoms such as loss of smell, rhinorrhea (anterior/posterior), etc? **Yes or No**

e. Did the member have an inadequate response to sinonasal surgery? **Yes or No**

f. Is the member a candidate for sinonasal surgery? **Yes or No**

g. Has the member tried an oral corticosteroid?
   □ **Yes**:
   - Please provide the dates the member tried an oral corticosteroid _____
   - Did the member have an inadequate response to oral corticosteroid therapy? **Yes or No**

   □ **No**: Please let us know the reason why not_____
   _____

h. Has the member tried topical intranasal corticosteroids (INCS)?
   □ **Yes**:
   - Please provide the dates the member tried topical intranasal corticosteroids (INCS)
     _____
   - Did the member have an inadequate response to topical intranasal corticosteroid (INCS)? **Yes or No**

   □ **No**: Can the member try topical intranasal corticosteroids (INCS)?
   □ Yes: Please notify the pharmacy of the change and return the form.
   □ No: Please provide the clinical reason why a topical intranasal corticosteroids (INCS) cannot be tried.
   _____

**i.** Will the member continue standard maintenance therapy (e.g., nasal saline irrigation, intranasal corticosteroids) in combination with Dupilumab (Dupixent)? **Yes or No**

□ **Other Diagnosis**: _____

**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 5 and 6 only for Subsequent Requests****

## Diagnosis

□ **Atopic Dermatitis (Eczema)**

1. Will success of treatment be assessed regularly and Dupixent will be discontinued if no adequate response after 16 weeks? **Yes or No**
   If **Yes**, has the member had at least a 4-point reduction in Dermatology Life Quality Index (DLQI) from when the treatment started? **Yes or No**

2. Will the member continue the use of topical emollients together with Dupixent in problem areas (e.g., face, neck, genitals) to prevent flares? **Yes or No**

3. What is the member's current weight _____ lb or _____ kg Date: _____

□ **Asthma**

1. How has the member responded to therapy compared to baseline? (check all that apply):
   - □ Reduction of the number of hospitalizations, need for mechanical ventilation, or visits to urgent care or emergency room due to asthma exacerbations
   - □ Reduction in dose inhaled/oral corticosteroids required to control the patient's asthma
   - □ Reduction in use of rescue medication
   - □ Increase in pulmonary function tests (e.g., Forced Expiratory Volume from baseline)
   - □ Decrease in symptoms and asthma exacerbations
   - □ None of the above
     - **If None of the above**, please provide any additional clinical information pertaining to the request.

     _____

     _____

2. Is the member currently being treated and has been compliant with standard asthma control therapy [e.g., inhaled corticosteroids, long-acting beta-2 agonist (LABA), leukotriene receptor antagonist (LTRA), long-acting muscarinic antagonist (LAMA), theophylline] for the past 90 days? **Yes or No**
   **If No**, please provide specific reason(s):
   _____

3. Will the member continue to use standard asthma control therapy [e.g., inhaled corticosteroids (ICS), long-acting beta-2-agonist (LABA), leukotriene receptor antagonist (LTRA), theophylline] with the requested drug?
   **Yes or No**
   **If Yes**, please provide the name(s) of the standard asthma control therapy the member will be receiving:
   _____

**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: _____

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

   **If Yes**, please provide drug name and diagnosis it is being used to treat:

   _____

□ **Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP)**

a. How has the member responded to therapy?
   - □ Reduction of systemic corticosteroid use
   - □ Decrease in nasal congestion/obstruction
   - □ Improvement in endoscopic nasal polyps score
   - □ Decrease in Lund-MacKay (LMK) sinus computed tomography (CT) scan score
   - □ Improvement in loss of smell
   - □ Decreased sino-nasal symptoms
   - □ None of the above

     **- If None of the above**, please provide any additional clinical information pertaining to the request.

     _____

b. Will the member continue standard maintenance therapy (e.g., nasal saline irrigation, intranasal corticosteroids) in combination with Dupilumab (Dupixent)? **Yes or No**

   **If Yes**, please provide the name(s) of the standard therapy the member will be receiving:

   _____

□ **Other Diagnosis**: _____

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