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# New Hampshire Medicaid AIDS Drug Assistance Program (ADAP) Prior Authorization 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 **7–12.**
2. Does the patient have a diagnosis of moderate to severe atopic dermatitis? ☐ Yes ☐ No
   If ***yes***, please answer questions **13–16.**
3. Does the patient have a diagnosis of chronic rhinosinusitis with nasal polyposis? ☐ Yes ☐ No
   If ***yes***, please answer questions **17–21.**
4. Does the patient have a diagnosis of eosinophilic esophagitis? ☐ Yes ☐ No
   If ***yes***, please answer questions **22–23.**

*(Form continued on next page.)*





Review date: 12/04/2024

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**PATIENT LAST NAME:**

**PATIENT FIRST NAME:**

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

5. Does the patient have a diagnosis of prurigo nodularis? ☐ Yes ☐ No
   If ***yes***, please answer questions **24–25.**
6. Does the patient have a diagnosis of chronic obstructive pulmonary disease (COPD)? ☐ Yes ☐ No
   If ***yes,*** please answer questions **26–31.**
7. Is a pulmonologist, allergist, or immunologist prescribing this medication, OR has one of these specialists been consulted in this case? ☐ Yes ☐ No
8. 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
9. Is the patient's blood eosinophil result > 150cells/mcL? _____ cells/mcL ☐ Yes ☐ No
10. Has the patient had at least one asthma exacerbation in the last year? ☐ Yes ☐ No
11. Does the patient require an oral corticosteroid to manage asthma? ☐ Yes ☐ No
12. Is this patient being treated exclusively for a peanut allergy? ☐ 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, tacrolimus, or Eucrisa® in the past? ☐ Yes ☐ No
    a. If ***yes***, provide drug name and duration of therapy:

    _____
17. Is an ear, nose, and throat (ENT) specialist prescribing this medication, OR has one been consulted in this case? ☐ Yes ☐ No
18. Is the patient ≥ 12 years old? ☐ Yes ☐ No

*(Form continued on next page.)*

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

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

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

19. Will Dupixent® (dupilumab) will be used as an add-on maintenance treatment? ☐ Yes ☐ No
20. 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
21. Has patient had a trial and failure of intranasal steroids? ☐ Yes ☐ No
    a. If ***yes***, provide drug name and duration of therapy:

    _____
22. Is a gastroenterologist, immunologist, or allergist prescribing this medication, OR has one been consulted in this case? ☐ Yes ☐ No
23. Is the patient ≥ 1 year of age AND ≥ 15 kg? ☐ Yes ☐ No
24. Is a dermatologist, immunologist, or allergist prescribing this medication, OR has one been consulted in this case? ☐ Yes ☐ No
25. Is the patient ≥ 18 years old? ☐ Yes ☐ No
26. Is the prescriber a pulmonologist or has one been consulted? ☐ Yes ☐ No
27. Is the patient ≥ 18 years old? ☐ Yes ☐ No
28. Is the baseline FEV-1% predicted between 30%–70%? ☐ Yes ☐ No
29. Is the patient's blood eosinophil result > 300 cells/mcL? _____ cells/mcL _____date
30. Is the patient receiving maximal inhaled therapy (LAMA/LABA/ICS)? ☐ Yes ☐ No

    Start date: _____
    If no, provide reason patient has not received LAMA/LABA/ICS.

    _____
31. Is the patient inadequately controlled? 2 moderate exacerbations (oral corticosteroid or antibiotic) or 1 severe exacerbation (hospitalization or ER visit) in the last 12 months ☐ Yes ☐ No

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**: _____

**Phone**: 1-800-424-7901
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