Iowa Department of Human Services

Request for Prior Authorization
Dupilumab (Dupixent)

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for Dupixent (dupilumab). Payment will be considered for patients when the following criteria are met:

1) Patient has a diagnosis of moderate-to-severe atopic dermatitis; and
2) Patient is within the FDA labeled age; and
3) Is prescribed by or in consultation with a dermatologist; and
4) Patient has failed to respond to good skin care and regular use of emollients; and
5) Patient has documentation of an adequate trial and therapy failure with one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; and
6) Patient has documentation of a previous trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and
7) Patient has documentation of a previous trial and therapy failure with cyclosporine or azathioprine; and
8) Patient will continue with skin care regimen and regular use of emollients; and
9) Dose does not exceed an initial one-time dose of 600mg and maintenance dose of 300mg thereafter given every other week.

If criteria for coverage are met, initial authorizations will be given for 16 weeks to assess the response to treatment. Requests for continuation of therapy will require documentation of a positive response to therapy. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Non-Preferred

☐ Dupixent

Strength	Usage Instructions	Quantity	Day's Supply

Diagnosis: _____

Is prescriber a dermatologist?

☐ Yes ☐ No If no, note consultation with dermatologist:

Consultation date: _____ Physician name & phone: _____

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Did patient fail to respond to good skin care and regular use of emollients?

☐ Yes ☐ No If yes, provide documentation below:

Provide skin care regimen, including name and dates of emollient use:_____

_____

Will patient continue skin care regimen and regular use of emollients? ☐ Yes ☐ No

Preferred medium to high potency topical corticosteroid trial:

Drug name & dose:_____ Trial dates:_____

Failure reason:_____

Topical immunomodulator trial:

Drug name & dose:_____ Trial dates:_____

Failure reason:_____

Cyclosporine or Azathioprine trial:

Drug name & dose:_____ Trial dates:_____

Failure reason:_____

Medical or contraindication reason to override trial requirements:_____

Renewal requests:

Document positive response to therapy:_____

_____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*