MEDICAL PRECERTIFICATION REQUEST FORM

Humana®

EOC ID:
Dupixent (dupilumab) 56
Phone: 1-866-461-7273 Fax back to: 1-888-447-3430

Humana manages the pharmacy drug benefit for your patient. Certain requests for precertification may require additional information from the prescriber. Please provide the following information and fax this form to the number listed above. **Information left blank or illegible may delay the review process.**

Patient name:	**Prescriber name:**	
Member/subscriber number:	Fax:	Phone:
Patient date of birth:	Office contact:	
Group number:	Tax ID:	NPI:
Address:	Address:	
City, state, ZIP:	City, state, ZIP:	
	Specialty/facility name (if applicable):	

If the patient is a Medicare Private Fee-for-Service member, which of the following apply?

I am giving notification. Yes____ No____

I am requesting an advanced coverage determination. Yes____ No____

☐ By checking this box, I am requesting multiple drug reviews for this patient.

Drug name and strength:	Dose per infusion/injection:
Directions/SIG:	Number of infusions/injections:
Quantity/units:	Number of cycles/frequency:

Is this a request for services already provided? Yes ___ No ___

If yes, please provide date of service: __/__/____

(Note: All reviews will be processed with generic equivalents for brand drugs whenever possible.)

Please attach pertinent medical history or information for this patient that may support approval, and sign this form.

Q1. Please provide diagnosis: *

Q2. Please provide ICD Diagnostic Codes

Q3. Please provide J-Code, if applicable:

Q4. Is the drug requested part of a clinical trial?

☐ Yes ☐ No

Q5. If yes, please provide the registration or identification number for the specific trial for which this drug is being studied (e.g. ClinicalTrials.gov Identifier: NCT12345678): _____

Q6. Please indicate where the drug is being dispensed? *

☐ Pharmacy dispensed to patient
☐ Pharmacy shipped to prescriber
☐ Prescriber dispensed
☐ Other

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Q7. If other, please specify:

Q8. Please provide the patient's age: (Mark all that apply) *

- ☐ Less than 12 years of age
- ☐ 12-17 years of age
- ☐ 18 years of age or older

Q9. Please indicate if this request is a: *

☐ New start/initial request ☐ Continuation/reauthorization request

Q10. For requests for atopic dermatitis, does the patient have documentation of positive clinical response: clinical reduction in pruritus and flares?

☐ Yes ☐ No

Q11. Is the request for a reauthorization for Asthma (moderate to severe), adjunct, eosinophilic phenotype or oral corticosteroid-dependent?

☐ Yes ☐ No

Q12. Has treatment with Dupixent resulted in clinical improvement as documented by one or more of the following:

- ☐ Decreased utilization of rescue medications
- ☐ Decreased frequency of exacerbations (defined as worsening of asthma that requires increase in inhaled corticosteroid dose or treatment with systemic corticosteroids)
- ☐ Reduction in reported asthma-related symptoms, such as, but not limited to, wheezing, shortness of breath, coughing, fatigue, sleep disturbance, or asthmatic symptoms upon awakening
- ☐ None of the above

Q13. Will the patient continue the use of inhaled corticosteroid plus LABA combination while on Dupixent therapy for asthma?

☐ Yes ☐ No

Q14. Will the patient be periodically reassessed for the need to continue therapy based on the disease severity and/or the level of asthma control?

☐ Yes ☐ No

Q15. For requests for chronic rhinosinusitis with nasal polyposis, has treatment with Dupixent resulted in clinical improvement documented in progress notes?

☐ Yes ☐ No

Q16. Will Dupixent be used in combination with other biologics (e.g.Xolair, Remicade, Enbrel, Humira)?

☐ Yes ☐ No

Q17. Does the patient have a parasitic infection?

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☐ Yes ☐ No

Q18. Has the patient had a trial of at least one preferred topical calcineurin inhibitor (e.g. Elidel, tacrolimus ointment) and experienced inadequate response or intolerance?

☐ Yes ☐ No

Q19. Has the patient had a trial of at least one preferred medium to very-high potency topical steroid (e.g. clobetasol propionate, fluticasone propionate, mometasone propionate) and experienced inadequate response or intolerance?

☐ Yes ☐ No

Q20. Does the patient have a diagnosis of asthma (moderate to severe), adjunct, eosinophilic phenotype or oral corticosteroid-dependent? *

☐ Yes ☐ No

Q21. Is the patient's diagnosis of asthma eosinophilic phenotype?

☐ Yes ☐ No

Q22. Has the patient had ongoing symptoms of asthma with a minimum three-month trial of an inhaled corticosteroid plus a long-acting beta 2 agonist (LABA) combination therapy?

☐ Yes ☐ No

Q23. Is Dupixent prescribed by or in consultation with any of the following (Please mark all that apply):

☐ allergist
☐ pulmonologist
☐ immunologist
☐ None of the above

Q24. Does the patient have any of the following (Please mark all that apply):

☐ Blood eosinophil count greater than or equal to 150 cells/mcL within the past six weeks while on oral corticosteroid
☐ Blood eosinophil count greater than or equal to 300 cells/mcL within the past year
☐ None of the above

Q25. Does the patient have a diagnosis of chronic rhinosinusitis (inflammation of the paranasal sinuses lasting more than 12 weeks) with nasal polyposis? *

☐ Yes ☐ No

Q26. Will Dupixent be add on therapy to first line treatment (intranasal or oral corticosteroids, nasal saline irrigations, and 3-4 week courses of antibiotics)?

☐ Yes ☐ No

Q27. Has the patient failed to achieve adequate control of symptoms with first line treatment (intranasal or oral corticosteroids, nasal saline irrigations, and 3-4 week courses of antibiotics)?

☐ Yes ☐ No

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Q28. Additional comments:

Prescriber signature

Date

I declare under penalty of perjury under the laws of the United States of America that the information provided is true and correct. This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document. 3149ALL0917-J 2019-11-01