



DUPIXENT (dupilumab) PRIOR AUTHORIZATION FORM (form effective 1/5/2026)

Prior authorization guidelines for Dupixent and Quantity Limits/Daily Dose Limits are available on the DHS Pharmacy Services website at <https://www.pa.gov/agencies/dhs/resources/for-providers/ma-for-providers/pharmacy-services>.

<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:			Specialty:	
Contact's phone number:			NPI:	State license #:
LTC facility contact/phone:			Street address:	
Beneficiary name:			City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:	

CLINICAL INFORMATION

Drug requested: Dupixent	Strength:	Formulation (pen, syringe, etc):	Weight: _____ lbs / kg	
Directions:			Quantity:	Refills:
Diagnosis (<i>submit documentation</i>):			Diagnosis code (<i>required</i>):	
Is Dupixent prescribed by or in consultation with a specialist (e.g., allergist, dermatologist, hematologist/oncologist, immunologist, pulmonologist, rheumatologist, etc.)?			<input type="checkbox"/> Yes <i>Submit documentation of consultation, if applicable.</i> <input type="checkbox"/> No	

Complete the section(s) below applicable to the beneficiary and this request and **SUBMIT DOCUMENTATION** for each item.

INITIAL requests

- For treatment of ASTHMA:** Indicate which of the following apply to the beneficiary. *Check all that apply.*
 - At least ONE of the following:
 - Has a diagnosis of asthma with an eosinophilic phenotype with an absolute blood eosinophil count ≥ 150 cells/microliter
 - Has a diagnosis of oral corticosteroid-dependent asthma
 - Has asthma that is moderate-to-severe
 - Has tried or cannot use standard asthma controller medications (e.g., inhaled corticosteroids, inhaled long-acting beta agonists [LABAs], etc.)
 - Will use Dupixent in addition to tolerated standard asthma controller medications (e.g., inhaled corticosteroids, inhaled LABAs, etc.)
- For treatment of chronic ATOPIC DERMATITIS (AD):** Indicate which of the following apply to the beneficiary. *Check all that apply.*
 - Has at least ONE of the following:
 - A BSA of $\geq 10\%$ that is affected
 - Involvement of critical areas (e.g., face, feet, genitals, hands, intertriginous areas, scalp)
 - Significant disability or impairment of physical, mental, or psychosocial functioning
 - Tried and failed or cannot try (due to intolerance or contraindication) BOTH of the of the following:
 - ONE of the following:
 - For the face, skin folds, or other critical areas, a 4-week trial of a low-potency (or higher) topical corticosteroid



- For other body areas, a 4-week trial of a medium potency or higher topical corticosteroid
- An 8-week trial of a topical calcineurin inhibitor (eg, pimecrolimus, tacrolimus)

3. For treatment of CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD):

- Has COPD that is inadequately controlled on standard COPD controller medications (e.g., inhaled steroids, inhaled LABAs, etc.)
- Will use Dupixent as an add-on maintenance treatment
- Has a diagnosis of COPD with an eosinophilic phenotype

4. For treatment of CHRONIC RHINOSINUSITIS WITH NASAL POLYPOSIS (CRSwNP):

- Has CRSwNP that is inadequately controlled on topical intranasal corticosteroids
- Will use Dupixent as an add-on maintenance treatment

5. For treatment of EOSINOPHILIC ESOPHAGITIS (EOE):

- Has tried and failed or cannot try (due to intolerance or contraindication) a proton pump inhibitor (eg, omeprazole, lansoprazole, etc)

6. For treatment of PRURIGO NODULARIS (PN):

- Has a history of pruritis for at least 6 weeks
- Has PN associated with at least ONE of the following:
 - ≥20 nodular lesions
 - Significant disability or impairment of physical, mental, or psychosocial functioning

7. For treatment of BULLOUS PEMPHIGOID:

- Has ONE of the following:
 - Tried and failed or has a contraindication or an intolerance to systemic corticosteroids
 - Has corticosteroid-dependent disease
- Tried and failed a corticosteroid-sparing therapy (e.g., doxycycline, dapsone, methotrexate, mycophenolate, azathioprine) or has a contraindication or an intolerance to these therapies

8. Other diagnosis – specify: _____

List other treatments tried (including start/stop dates, dose, outcomes, etc.): _____

RENEWAL requests

1. For the treatment of ASTHMA:

- Has documented measurable evidence of improvement in the beneficiary's asthma
- Maintained asthma control while decreasing the oral corticosteroid dose
- Is using Dupixent in addition to tolerated standard asthma controller medications (e.g., inhaled corticosteroids, inhaled LABAs, etc.)

2. For the treatment of ALL OTHER diagnoses:

- Has documented evidence of improvement in disease severity

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:

Date:

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