EXPRESS SCRIPTS®

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Prior Authorization Request

DUPIXENT (dupilumab)

Instructions

Please complete Part A and have your physician complete Part B. Completion and submission is not a guarantee of approval. Any fees related to the completion of this form are the responsibility of the plan member. Drugs in the Prior Authorization Program may be eligible for reimbursement if the patient does not qualify for coverage under a primary plan or a government program. Drugs used for indications not approved by Health Canada may be denied. For Quebec plan members, RAMQ exception drug criteria may apply. The decision for approval versus denial is based on pre-defined clinical criteria, primarily based on Health Canada approved indication(s) and on supporting evidence-based clinical protocols. The plan member will be notified whether their request has been approved or denied. Please note that you have the right to appeal the decision made by Express Scripts Canada.

Part A – Patient

Patient information

First Name:	Last Name:	
Insurance Carrier Name/Number:		
Group Number:	Client ID:	
Date of Birth (YYYY/MM/DD):	Relationship: ☐ Employee ☐ Spouse ☐ Dependent	
Language: ☐ English ☐ French	Gender: ☐ Male ☐ Female	
Address:		
City:	Province:	Postal Code:
Email address:		
Telephone (home):	Telephone (cell):	Telephone (work):

Coordination of benefits

Patient Assistance Program	Is the patient enrolled in any patient assistance program? ☐ Yes ☐ No Contact Name: _____ Fax: _____
Provincial Coverage	Has the patient applied for reimbursement under a provincial plan? ☐ Yes ☐ No ☐ N/A What is the coverage decision of the drug? ☐ Approved ☐ Denied ***Attach decision letter****
Primary Coverage	Has the patient applied for reimbursement under a primary plan? ☐ Yes ☐ No ☐ N/A What is the coverage decision of the drug? ☐ Approved ☐ Denied ***Attach decision letter****

Authorization

On behalf of myself and my eligible dependents, I authorize my group benefit provider, and its agents, to exchange the personal information contained on this form. I give my consent on the understanding that the information will be used solely for purposes of administration and management of my group benefit plan. This consent shall continue so long as my dependents and I are covered by, or are claiming benefits under the present group contract, or any modification, renewal, or reinstatement thereof.

_____ _____

Plan Member Signature Date

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Part B – Prescriber

Please see instructions on page 1 and complete all sections below. Incomplete forms may result in automatic denial. Please do **not** provide genetic test information or results.

SECTION 1 – DRUG REQUESTED

DUPIXENT (dupilumab)		☐ New request	☐ Renewal request*
Dose	Administration (ex: oral, IV, etc)	Frequency	Duration

Site of drug administration:

☐ Home ☐ Physician's office/Infusion clinic ☐ Hospital (outpatient) ☐ Hospital (inpatient)

* Please submit proof of prior coverage if available

SECTION 2 – ELIGIBILITY CRITERIA

1. Please indicate if the patient satisfies the below criteria:

Atopic Dermatitis

INITIAL

- ☐ For the treatment of moderate-to-severe atopic dermatitis (AD), AND
- ☐ The patient is 6 months of age or older, AND
- ☐ The patient has an affected body surface area (BSA) of 10% or greater, or there is involvement of the patient's face, hands, feet or genital region, AND
- ☐ The patient has an Investigator's Global Assessment (IGA) score of 3 or greater, AND
- ☐ The patient has an Eczema Area and Severity Index (EASI) score of 16 or greater, AND
- ☐ The patient has had an inadequate response or has a documented intolerance to at least 2 topical agents that are high potency corticosteroids or calcineurin inhibitors *(Please list prior therapies in the chart below)*, AND
- ☐ The patient has had an inadequate response or has a documented intolerance to a systemic treatment, if an adult *(Please list prior therapies in the chart below)*

RENEWAL

- ☐ The patient has demonstrated improvement defined as 75% or greater improvement from baseline in EASI score. Please indicate patient's baseline and current EASI score below:

BASELINE		CURRENT	
Date (YYYY-MM-DD)	EASI score	Date (YYYY-MM-DD)	EASI score

Asthma – Type 2/Eosinophilic Phenotype

INITIAL

- ☐ For the add-on maintenance treatment of severe asthma with a type 2/eosinophilic phenotype, AND
- ☐ The patient is 6 years of age or older, AND
- ☐ The patient is inadequately controlled with high-dose inhaled corticosteroids, and 1 or more additional asthma controller(s) (e.g. long-acting beta agonists) *(Please list prior therapies in the chart below)*, AND
- ☐ The patient has a blood eosinophil count of 150 cells/mm^3 or greater. Please indicate patient's blood eosinophil count (cells/mm^3) below, AND

Date (YYYY-MM-DD)	Blood eosinophil count (cells/mm^3)

- ☐ The patient has a forced expiratory volume in 1 second (FEV1) less than 80% of predicted normal for an adult, or 90% or less of predicted normal for an adolescent. Please indicate patient's FEV1 below:

Date (YYYY-MM-DD)	FEV1

RENEWAL

- ☐ The patient has demonstrated clinical improvement from baseline (e.g. a reduction in the number of asthma exacerbations, a decrease in administration of rescue medication)

Asthma – Corticosteroid-Dependent

INITIAL

- ☐ For the add-on maintenance treatment of severe asthma with oral corticosteroid-dependence, AND
- ☐ The patient is 6 years of age or older, AND
- ☐ The patient has been treated with an oral corticosteroid daily for at least 6 months *(Please list prior therapies in the chart below)*, AND
- ☐ The patient is inadequately controlled with high-dose inhaled corticosteroids, and 1 or more additional asthma controller(s) (e.g. long-acting beta agonists) *(Please list prior therapies in the chart below)*

RENEWAL

- ☐ The patient has demonstrated clinical improvement from baseline (e.g. a reduction in the number of asthma exacerbations, a decrease in daily oral corticosteroid use, a decrease in administration of rescue medication)

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Chronic Rhinosinusitis with Nasal Polyposis

INITIAL

- ☐ For the treatment of severe chronic rhinosinusitis with nasal polyposis (CRSwNP) in an adult, AND
- ☐ The patient has a nasal polyp score (NPS) of 5 or greater, AND
- ☐ The patient has a nasal congestion (NC) score of 2 or greater, AND
- ☐ The patient has been treated with sinus surgery, OR
- ☐ The patient has had an inadequate response or has a documented intolerance to at least 2 nasal corticosteroids, and to an oral corticosteroid *(Please list prior therapies in the chart below)*

RENEWAL

- ☐ The patient has demonstrated clinical improvement from baseline (e.g. a reduction in nasal polyp size, a reduction in nasal congestion, a reduced need for systemic corticosteroids)

Eosinophilic Esophagitis

INITIAL

- ☐ For the treatment of eosinophilic esophagitis (EoE), AND
- ☐ The patient is 12 years of age or older, AND
- ☐ The patient weighs 40kg or more, AND
- ☐ The patient has a diagnosis of eosinophilic esophagitis as confirmed by an endoscopic biopsy demonstrating 15 or greater intraepithelial eosinophils per high-power field (eos/hpf), AND
- ☐ The patient has a Dysphagia Symptom Questionnaire (DSQ) score of 10 or greater, AND
- ☐ The patient has had an inadequate response or has a documented intolerance to either an 8-week course of high-dose proton pump inhibitor (PPI) or a topical glucocorticoid *(Please list prior therapies in the chart below)*

RENEWAL

- ☐ The patient has demonstrated clinical improvement from baseline (e.g. a reduced intraepithelial eosinophil count, a decrease in DSQ score)

Prurigo Nodularis

- ☐ For the treatment of moderate to severe prurigo nodularis (PN) in an adult, AND
- ☐ The patient has an average worst itch score of 7 or greater on the Worst-Itch Numeric Rating Scale (WI-NRS) ranged from 0 to 10, AND
- ☐ The patient has 20 or greater nodular lesions, AND
- ☐ The patient has had an inadequate response or has a documented intolerance to medium to ultra-high potency topical corticosteroids *(Please list prior therapies in the chart below)*

OR

☐ None of the above criteria applies.

Relevant additional information:

2. Please list previously tried therapies

Drug	Dosage and administration	Duration of therapy		Reason for cessation	
		From	To	Inadequate response	Allergy/ Intolerance
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐

SECTION 3 – PRESCRIBER INFORMATION

Physician's Name:	
Address:	
Tel:	Fax:
License No.:	Specialty:
Physician Signature:	Date:

Please fax or mail the completed form to Express Scripts Canada®

Fax: Express Scripts Canada Clinical Services
1 (855) 712-6329

Mail: Express Scripts Canada Clinical Services
5770 Hurontario Street, 10th Floor
Mississauga, ON L5R 3G5