

**PRIOR AUTHORIZATION PROGRAM REIMBURSEMENT REQUEST FORM**  
**For biologic response modifier therapy: Dupixent (dupilumab)**

Please fax form to:  
**1-866-840-1509**

Please note that the patient AND physician must complete this form. All fields are mandatory and must be completed. Incomplete forms may result in your application being declined. Please retain a copy of this form for your records.

**Instructions:**

1. **PLEASE PRINT CLEARLY AND COMPLETE ALL SECTIONS.**
2. The patient/plan member must complete section A.
3. Your physician must complete section B. The cost, if any, of completing this form is at the expense of the patient/plan member.
4. Please return the form to your insurance company via Pharmacy Services at TELUS Health (a service provider of your insurance company) by fax to **1-866-840-1509**.
5. If you have any questions on the application of this program or the decision on reimbursement, or to inquire on the status of your Reimbursement Request Form, please contact your insurer.

<b>A. Information to be Completed by Patient</b>		
Employee or Insured's Name	Drug Card Number ____ - ____ - ____ - ____ - ____	
Patient's Name	Patient's Date of Birth (DD/MMM/YYYY) __ / __ / ____	Relationship to Employee/Insured <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent
<p><b>Please allow two business days for a response once all information is received and complete.</b>  <b>Notification of the results of this request will occur Monday to Friday between 9 am and 4 pm Eastern Time.</b></p>		

Please provide contact information and indicate **ONE** method of preferred contact for notification of the results:

<input type="checkbox"/> E-mail	<input type="checkbox"/> Call me (and leave a message if I'm not there)	<input type="checkbox"/> Fax me at:
<input type="checkbox"/> Contact my pharmacy: Pharmacy Name	Pharmacy Phone Number	

I certify that the information provided by me is true, correct and complete to the best of my knowledge. I authorize my insurance company, TELUS Health (a service provider of my insurance company), their authorized representatives, agents and service providers to use and exchange this information needed for underwriting, administration and paying claims with any person or organization who has relevant information pertaining to this claim including health professionals, institutions and investigative agencies in the event of an audit. I authorize my insurance company and/or TELUS Health (a service provider of my insurance company) to contact any licensed physician, institution, pharmacy or person who has any records or knowledge of me or my health with respect to this submitted claim.

SIGNATURE OF PATIENT/PARENT/LEGAL GUARDIAN \_\_\_\_\_

Date: (DD/MMM/YYYY): \_\_ / \_\_ / \_\_\_\_

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**B. Information to be Completed by Prescribing Physician**

Drug Name	Strength	Dose
Dupixent (dupilumab)		

**Dupixent (dupilumab) will be eligible for reimbursement only if the patient satisfies the conditions listed below and if the patient does not qualify for coverage under any other drug plan or government mandated program.** If the patient is covered under another drug plan or government mandated program, the prior authorization program, as part of your drug benefits, may cover the portion not paid for by the primary plan. If “None of the above criteria” is indicated, the patient will not be eligible for reimbursement. **For Quebec plan members, please refer to the RAMQ exception drug criteria, if applicable.**

**Eligibility Criteria**

Please indicate if the patient satisfies the following criteria:

**Initial Criteria (approval period of 6 months):**

- Atopic Dermatitis (AD) (24079001)
  - The prescriber is a dermatologist or works in consultation with a dermatologist; AND
  - The patient:
    - Has a diagnosis of moderate to severe atopic dermatitis; AND
    - Is aged  $\geq 6$  years; AND
    - Has an affected body surface area  $\geq 10\%$ ; AND
    - Has an inadequate response to each of the following :
      - Two or more medium to high or very high potency topical corticosteroids, each used for 2 or more weeks; OR
        - Contraindication to topical corticosteroids; AND
      - One non-steroidal topical calcineurin inhibitor therapy (e.g. tacrolimus or pimecrolimus) used for 3 to 6 weeks; OR
        - Contraindication to topical calcineurin inhibitors; AND
      - One or more systemic agents such as corticosteroids, azathioprine, methotrexate, mycophenolate mofetil, or cyclosporine; OR
        - Contraindication to systemic therapy

OR

- Chronic Rhinosinusitis with Naasal Polyposis (CRSwNP) (41931000119102)
  - The prescriber is an otolaryngologist, allergist or immunologist or works in consultation with an otolaryngologist, allergist or immunologist; AND
  - The patient:
    - Is  $\geq 18$  years of age; AND
    - Has diagnosis of CRSwNP, meeting all of the following:
      - Presence of at least 2 of the following major symptoms (moderate to severe) for 8 to 12 weeks:
        - Facial congestion or fullness
        - Facial pain, pressure, or fullness
        - Nasal obstruction or blockage
        - Purulent anterior or posterior nasal drainage
        - Hyposmia or anosmia (smell); AND
      - Documented inflammation of the paranasal sinuses or nasal mucosa; AND
      - At least 1 objective finding of the above confirmed on endoscopy or CT; AND
      - Presence of at least 1 of the following:
        - Bilateral polyps in middle meatus on endoscopy; OR
        - Bilateral mucosal disease on CT scan;

AND

- Has required treatment with 1 of the following:

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**Eligibility Criteria**

- Systemic corticosteroids (SCS) within the past 2 years (or had medical contraindication / intolerance to SCS); OR
- Prior surgery for nasal polyposis;

AND

- Has been unable to obtain symptom relief after trial of 2 of the following classes of agents:
  - Nasal saline irrigations
  - Intranasal corticosteroids (e.g. fluticasone, mometasone, triamcinolone, etc.)
  - Antileukotriene agent (e.g. montelukast);

AND

- Will use Dupixent as add-on maintenance treatment with intranasal corticosteroids; AND
- Is not receiving Dupixent in combination with another biologic medication [e.g., Xolair (omalizumab), Nucala (mepolizumab), Cinqair (reslizumab), Fasentra (benralizumab)]

OR

- Severe asthma (370221004)
  - The prescriber is a respirologist or works in consultation with a respirologist; AND
  - The patient:
    - Is 12 years of age or older; AND
    - Has severe asthma with a type 2/eosinophilic phenotype, OR
    - Has oral corticosteroid-dependent asthma, AND
      - Has been receiving regular prescribed treatment of maintenance corticosteroids in the past 6 months and using a stable OCS dose for the past four weeks, AND
    - Is receiving existent treatment with moderate to high dose inhaled corticosteroid in combination with a second controller (e.g. long-acting beta-agonist, leukotriene receptor antagonist) for at least three months, AND
    - Is not receiving Dupixent in combination with another biologic medication [e.g., Xolair (omalizumab), Nucala (mepolizumab), Cinqair (reslizumab), Fasentra (benralizumab)]

**Renewal Criteria (approval period of 1 year):**

- Atopic Dermatitis (AD) (24079001)
  - The patient has responded to Dupixent therapy (e.g., marked improvements in terms of erythema, induration/papulation/edema, excoriations, and lichenification; reduced pruritus; reduced body surface area (BSA) affected with atopic dermatitis; etc.); AND
  - Member has had an improvement of at least 2 points on the Investigator's Global Assessment (IGA) score from initiation of treatment

OR

- Chronic Rhinosinusitis with Naasal Polyposis (CRSwNP) (41931000119102)
  - The patient:
    - Has documented positive clinical response to Dupixent therapy; AND
    - Will continue to receive Dupixent as add-on maintenance therapy in combination with intranasal corticosteroids; AND
    - Is not receiving Dupixent in combination with another biologic medication [e.g., Xolair (omalizumab), Nucala (mepolizumab), Cinqair (reslizumab), Fasentra (benralizumab)]

OR

- Severe asthma (370221004)
  - The patient has demonstrated clinical improvement as demonstrated by one or more of the following:
    - Increase in percent predicted FEV<sub>1</sub> from pretreatment baseline, OR
    - Decreased use of rescue medications from pretreatment baseline, OR

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Eligibility Criteria	
<input type="checkbox"/> Decreased frequency of exacerbations requiring an increase in inhaled corticosteroid dose or systemic corticosteroid use from pretreatment baseline	
OR	
<input type="checkbox"/> None of the above applies	
Relevant additional information _____	

Physician Information				
Physician's Name	License Number	Telephone Number	Fax Number	
Address		City	Province	Postal Code
Physician's Signature			Date: (DD/MMM/YYYY) ____ / ____ / ____	