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.

A. Information to be Completed by Patient

Employee or Member's Name	Drug Card Number __ __ - __ __ __ __ __ __ - __ __ __ __ __ __ __ __ __ __ - __ __	
Patient's Name	Patient's Date of Birth (DD/MMM/YYYY) __ __ / __ __ __ / __ __ __ __	Relationship to Employee/Member ❑ Member ❑ Spouse ❑ Dependent

Please allow two business days for a response once all information is received and complete.
Notification of the results of this request will occur Monday to Friday between 9 a.m. and 4 p.m. Eastern Time.

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

❑ E-mail	❑ Call me (and leave a message if I'm not there)	❑ Fax me at:
❑ 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:
  - ❑ Is aged ≥ 6 months; AND
  - ❑ Weighs ≥ 5 kg; AND
  - ❑ Has a diagnosis of moderate to severe atopic dermatitis ; AND
  - ❑ Has an affected body surface area ≥ 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 Nasal 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 ≥ 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;

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Eligibility Criteria

AND
- ❑ Has required treatment with 1 of the following:
  - ❑ 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. omalizumab, mepolizumab, resilizumab, benralizumab)

OR

❑ **Severe asthma (370221004)**
- ❑ The prescriber is a respirologist or works in consultation with a respirologist; AND

The patient:
- ❑ Is 6 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. omalizumab, mepolizumab, resilizumab, benralizumab);

OR

❑ **Eosinophilic Esophagitis (235599003)**
- ❑ The prescriber is an allergist or gastroenterologist, or works in consultation with an allergist or gastroenterologist; AND

The patient:
- ❑ Is 1 year of age or older; AND
- ❑ Weighs at least 15 kg; AND
- ❑ Has a diagnosis of eosinophilic esophagitis as confirmed by an endoscopic biopsy demonstrating ≥15 intraepithelial eosinophils per high-power field (eos/hpf); AND
- ❑ Has received at least an 8-week course of a high-dose proton pump inhibitor (PPI) or topical corticosteroids; AND
- ❑ Meets <u>one</u> of the following regarding the Dysphagia Symptom Questionnaire (DSQ) score:
  - ❑ Has a DSQ score ≥10 on a scale of 0 to 84; OR
  - ❑ If 1 to <12 years of age, DSQ is not applicable

OR

❑ **Prurigo Nodularis (PN, 63501000)**
- ❑ The prescriber is a dermatologist, allergist, immunologist or works in consultation with those specialists; AND

The patient:
- ❑ Is ≥ 18 years of age; AND

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Eligibility Criteria

- ❑ Has received a clinical diagnosis of moderate-to-severe PN defined by all the following:
  - ❑ Has been diagnosed by a dermatologist for at least 3 months; AND
  - ❑ Has an average worst itch score of greater than or equal to ≥ 7 on the Worst-Itch Numeric Rating Scale (WI-NRS) ranged from 0 to 10; AND
  - ❑ Has a minimum of 20 PN lesions in total on both legs, and/or both arms and/or trunk; AND
  - ❑ Has a history of failing a 2-week course of medium-to-super potent TCS; OR
    - ❑ TCS are not medically advisable

❑ **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
- ❑ 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 Nasal 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. omalizumab, mepolizumab, resilizumab, 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_1 from pretreatment baseline; OR
- ❑ Decreased use of rescue medications from pretreatment baseline; OR
- ❑ Decreased frequency of exacerbations requiring an increase in inhaled corticosteroid dose or systemic corticosteroid use from pretreatment baseline

OR

❑ **Eosinophilic Esophagitis (235599003)**
The patient has demonstrated clinical improvement as demonstrated by one or more of the following:
- ❑ Reduced intraepithelial eosinophil count; OR
- ❑ Decreased dysphagia/pain upon swallowing; OR
- ❑ Reduced frequency/severity of food impaction.

OR

❑ **Prurigo Nodularis (PN, 63501000)**
The patient has experienced a beneficial clinical response, defined by ONE of the following:
- ❑ Reduced nodular lesion count; OR
- ❑ Decreased pruritus; OR
- ❑ Reduced nodular lesion size.

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Eligibility Criteria
OR ❑ None of the above applies Relevant additional information _____

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

The most current version of this form supersedes all prior versions. The form may be modified without notice to you and we reserve the right to accept only the current version. **Revised September 2024. Dupixent-2409**