Dupixent

HMSACOM - Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-237-5512**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-808-254-4414.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Patient's Phone Number: _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Additional Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*ft* _____*inches*

Indicate where the drug is being dispensed:

❑ Office ❑ Outpatient Hospital ❑ Ambulatory Surgical ❑ Inpatient Hospital
❑ Off Campus Outpatient Hospital ❑ Urgent Care ❑ Emergency Room ❑ Birthing Center
❑ Military Facility ❑ Skilled Nursing Facility ❑ Nursing Facility ❑ Hospice
❑ Inpatient Psychiatric ❑ Psychiatric Residential Treatment ❑ End Stage Renal Facility
❑ Psychiatric Facility ❑ Pharmacy ❑ Other

Indicate where the drug is being administered:

❑ Ambulatory surgical ❑ Home ❑ Inpatient hospital ❑ Office
❑ Outpatient Hospital ❑ Pharmacy

What is the ICD-10 code? _____

Criteria Questions:

1. Will the requested drug be used concomitantly with any other biologic or targeted synthetic drug for the same indication?
❒ Yes, *Continue to #2*
❒ No, *Continue to #2*

2. What is the diagnosis?
❒ Atopic dermatitis, moderate-to-severe, *Continue to #3*
❒ Asthma, moderate-to-severe, *Continue to #125*
❒ Chronic rhinosinusitis with nasal polyposis, *Continue to #175*
❒ Eosinophilic esophagitis, *Continue to #200*
❒ Prurigo Nodularis, *Continue to #250*
❒ Immune checkpoint inhibitor-related toxicity, *Continue to #300*
❒ Other, *No Further Questions*

Atopic Dermatitis

3.Is the member 6 months of age or older?
❒ Yes, *Continue to #4*
❒ No, *Continue to #4*

4. Is the requested drug prescribed by or in consultation with a dermatologist or allergist/immunologist?
❒ Yes, *Continue to #5*
❒ No, *Continue to #5*

5. Is the patient currently receiving treatment with the requested medication?
❒ Yes, *Continue to #6*
❒ No, *Continue to #20*

6. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?
❒ Yes, *Continue to #20*
❒ No, *Continue to #7*
❒ Unknown, *Continue to #20*

Continuation of Therapy

7. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity (i.e., clear or almost clear skin) or improvement in signs and symptoms of atopic dermatitis (e.g., redness, itching, oozing/crusting) since starting treatment with the requested drug? ***ACTION REQUIRED**: If 'Yes', please attach supporting chart note(s) showing that the patient has experienced a positive clinical response to therapy as evidenced by low disease activity or improvement in signs or symptoms*
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

New Starts

20. Has the patient received or is currently receiving a biologic (e.g., Adbry) or targeted synthetic drug (e.g.g, Cibinqo, Rinvoq) within in the past 180 days indicated for the treatment of moderate-to-severe atopic dermatitis (excluding receiving the drug via samples or a manufacturer's patient assistance program)?
❒ Yes, *No Further Questions*
❒ No, *Continue to #21*

21. What is the percentage of body surface area (BSA) affected prior to initiation of the requested medication? ***ACTION REQUIRED**: **Please attach supporting chart note(s) or medical record indicating affected areas and body surface area***
❒ Less than 10% of BSA, *Continue to #22*
❒ Greater than or equal to 10% of BSA, *Continue to #23*

22. Are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected? ***ACTION REQUIRED**: **If 'Yes', please attach supporting chart note(s) or medical record indicating affected area(s)***
❒ Yes, *Continue to #23*
❒ No, *No Further Questions*

23. Has the patient had an inadequate treatment response with a high potency or super-high potency topical corticosteroid in the past 180 days? ***ACTION REQUIRED**: **If 'Yes', please attach supporting chart note(s) or medical record and claims history showing drug names, dosage form, strength, dosage, duration, and response to therapy***
❒ Yes, *Continue to #24*
❒ No, *Continue to #25*

24. Please indicate the active ingredient, strength, and dosage form of the high potency to super-high potency topical steroids tried by the patient in the past 180 days: _____, *No Further Questions*

25. Has the patient had an inadequate treatment response with a topical calcineurin inhibitor in the past 180 days? ***ACTION REQUIRED**: **If Yes, please attach chart note(s), medical record, or claims history supporting prerequisite therapies including drug name, dosage form, strength, and response to therapy***
❒ Yes, *No Further Questions*
❒ No, *Continue to #26*

26.Is the use of high potency to super-high potency topical corticosteroids not advisable for the patient (e.g., due to contraindications, prior intolerances, potency not appropriate for member's age)? ***ACTION REQUIRED**: **If 'Yes', please attach supporting documentation of why therapy is not advisable***
❒ Yes, *Continue to #27*
❒ No, *No Further Questions*

27. Is the use of topical calcineurin inhibitors not advisable for the patient (e.g., due to contraindications, prior intolerances)? ***ACTION REQUIRED**: **If 'Yes', please attach supporting documentation of why therapy is not advisable***
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

Asthma

125.Is the requested drug being prescribed by or in consultation with an allergist/immunologist or a pulmonologist?
❒ Yes, *Continue to #126*
❒ No, *Continue to #126*

126. Is the patient 6 years of age or older?
❒ Yes, *Continue to #127*
❒ No, *Continue to #127*

127. Is the request for continuation of therapy with the requested drug?
❒ Yes, *Continue to #128*
❒ No, *Continue to #150*

128. Is the patient currently receiving Dupixent through samples or a manufacturer's patient assistance program?
❒ Yes, *Continue to #150*
❒ No, *Continue to #129*
❒ Unknown, *Continue to #150*

Continuation of Therapy

129. Has asthma control improved on Dupixent treatment, as demonstrated by at least one of the following: A) A reduction in the frequency and/or severity of symptoms and exacerbations, or B) A reduction in the daily maintenance oral corticosteroid dose? ***ACTION REQUIRED: If 'Yes', please attach supporting chart notes or medical record documentation of improved asthma control***
❒ Yes, *Continue to #130*
❒ No, *Continue to #130*

130. Will the patient continue to use maintenance asthma treatments (e.g., inhaled corticosteroid, additional controller) in combination with Dupixent?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

New Starts

150. Has the patient previously received in the past year or is currently receiving a biologic drug (e.g., Nucala, Cinqair) indicated for treatment of asthma (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including drug, dose, frequency, and duration***
❒ Yes, *No Further Questions*
❒ No, *Continue to #151*

151. Does the patient have uncontrolled asthma as demonstrated by experiencing two or more asthma exacerbations requiring oral or injectable corticosteroid treatment within the past year? ***ACTION REQUIRED: If yes, please submit supporting chart notes, medical records, or claims history of previous corticosteroid use for asthma exacerbations***
❒ Yes, *Continue to #154*
❒ No, *Continue to #152*

152.Does the patient have uncontrolled asthma as demonstrated by experiencing one or more asthma exacerbation(s) resulting in hospitalization or emergency medical care visit within the past year? ***ACTION REQUIRED: If yes, please submit supporting chart notes, medical records of previous asthma exacerbations requiring hospitalization or emergency medical visit***
❒ Yes, *Continue to #154*
❒ No, *Continue to #153*

153. Does the patient have uncontrolled asthma as demonstrated by experiencing poor symptom control (frequent symptoms or reliever use, activity limited by asthma, night waking due to asthma) within the past year? ***ACTION REQUIRED: If yes, please submit supporting chart notes or medical records showing poor symptom control***
❒ Yes, *Continue to #154*
❒ No, *Continue to #154*

154. Prior to Dupixent therapy, what is the patient's baseline (e.g., before significant oral steroid use) blood eosinophil count in cells per microliter?

ACTION REQUIRED**: **Please attach supporting chart note(s) or medical record with the patient's pre-treatment blood eosinophil count

❒ Greater than or equal to 150 cells per microliter, *Continue to #155*
❒ Less than 150 cells per microliter, *Continue to #156*
❒ Unknown, *Continue to #156*

155. Prior to requesting Dupixent, did the patient have inadequate asthma control despite current treatment with both of the following medications at optimized doses: A) Medium-to-high-dose inhaled corticosteroid, and B) Additional controller (i.e., long acting beta2-agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline)? ***ACTION REQUIRED: If 'Yes', please attach supporting chart notes, medical records, or claims history of previous medications tried including drug, dose, frequency, and duration***

❒ Yes, *Continue to #159*
❒ No, *Continue to #159*

156. Prior to requesting Dupixent, did the patient have inadequate asthma control despite concomitant treatment with all of the following medications at optimized doses: A) High-dose inhaled corticosteroid, B) Additional controller (i.e., long acting beta2-agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline), and C) Oral glucocorticoids (at least 5 mg per day of prednisone/prednisolone or equivalent)? ***ACTION REQUIRED**: **If 'Yes', please attach supporting chart note(s) or medical record showing prior therapies.For oral glucocorticoids use history, please include drug, dose, frequency and duration***

❒ Yes, *Continue to #157*
❒ No, *Continue to #157*

157. Has the patient received treatment with the inhaled corticosteroid and additional controller for at least the previous 3 months? ***ACTION REQUIRED**: **If 'Yes', please attach supporting chart notes, medical records, or claims history of previous medications tried including drug, dose, frequency, and duration***

❒ Yes, *Continue to #158*
❒ No, *Continue to #158*

158. Has the patient received treatment with oral glucocorticoids for most days during the previous 6 months (e.g., 50% of days, 3 steroid bursts in the previous 6 months)? ***ACTION REQUIRED**: **If 'Yes', please attach chart notes, medical records, or claim history of oral glucocorticoid use in the previous 6 months***

❒ Yes, *Continue to #159*
❒ No, *Continue to #159*

159.Will the patient continue to use maintenance asthma treatments (e.g., inhaled corticosteroid, additional controller) in combination with Dupixent?

❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

Chronic rhinosinusitis with nasal polyposis

175. Is the requested drug being prescribed by or in consultation with an allergist/immunologist or an otolaryngologist?

❒ Yes, *Continue to #176*
❒ No, *Continue to #176*

176. Is the patient an adult?

❒ Yes, *Continue to #177*
❒ No, *Continue to #177*

177. Is the request for continuation of therapy with the requested drug?
❒ Yes, *Continue to #178*
❒ No, *Continue to #182*

178. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?
❒ Yes, *Continue to #182*
❒ No, *Continue to #179*
❒ Unknown, *Continue to #182*

Continuation of Therapy

179. Has the patient achieved or maintained positive clinical response as evidenced by improvement in signs and symptoms of chronic rhinosinusitis with nasal polyposis (CRSwNP) (e.g., improvement in nasal congestion, nasal polyp size, loss of smell, anterior or posterior rhinorrhea, sinonasal inflammation, hyposmia and/or facial pressure or pain or reduction in corticosteroid use)? ***ACTION REQUIRED**: If 'Yes', please attach supporting chart notes or medical record documentation of positive clinical response*
❒ Yes, *Continue to #180*
❒ No, *Continue to #180*

180. Will the patient continue to use a daily intranasal corticosteroid while being treated with Dupixent?
❒ Yes, *No Further Questions*
❒ No, *Continue to #181*

181. Are intranasal corticosteroids contraindicated or not tolerated?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

New Starts

182. Has the patient received in the past year or is currently receiving a biologic drug (e.g., Nucala, Xolair) indicated for treatment of chronic rhinosinusitis with nasal polyposis (CRSwNP)? ***ACTION REQUIRED**: If Yes, please attach chart note(s), medical record documentation, or claims history supporting previous medications tried, including drug, dose, frequency, and duration*
❒ Yes, *No Further Questions*
❒ No, *Continue to #183*

183. Does the patient have bilateral nasal polyposis and chronic symptoms of sinusitis?
❒ Yes, *Continue to #184*
❒ No, *Continue to #184*

184. Has the patient had intranasal corticosteroid treatment for at least 2 months? ***ACTION REQUIRED**: If 'Yes', please attach supporting chart notes, medical records, or claims history of previous medications tried*
❒ Yes, *Continue to #186*
❒ No, *Continue to #185*

185. Are intranasal corticosteroids contraindicated or not tolerated? ***ACTION REQUIRED**: If 'Yes', please attach documentation of clinical reason to avoid therapy*
❒ Yes, *Continue to #186*
❒ No, *Continue to #186*

186. Has the patient had prior sino-nasal surgery?
❒ Yes, *Continue to #189*
❒ No, *Continue to #187*

187. Has the patient had an inadequate response with systemic corticosteroids within the last two years? ***ACTION REQUIRED**: If 'Yes', please attach supporting chart notes, medical records, or claims history of previous medications tried*
❒ Yes, *Continue to #189*
❒ No, *Continue to #188*

188. Are systemic corticosteroids contraindicated or not tolerated? ***ACTION REQUIRED**: If 'Yes', please attach documentation of clinical reason to avoid therapy*
❒ Yes, *Continue to #189*
❒ No, *Continue to #189*

189. Has the patient had a bilateral nasal endoscopy, anterior rhinoscopy, or computed tomography (CT) showing polyps reaching below the lower border of the middle turbinate or beyond in each nostril? ***ACTION REQUIRED**: If 'Yes', please attach supporting chart note(s) or medical record showing endoscopy, rhinoscopy, or CT details (e.g., polyps location, size)*
❒ Yes, *Continue to #192*
❒ No, *Continue to #190*

190. Does the patient have a Meltzer Clinical Score of 2 or higher in both nostrils? ***ACTION REQUIRED**: If 'Yes', please submit chart notes or medical records of Meltzer Clinical score*
❒ Yes, *Continue to #192*
❒ No, *Continue to #191*

191. Does the patient have a total endoscopic nasal polyps score (NPS) of at least 5 with a minimum score of 2 for each nostril? ***ACTION REQUIRED**: If 'Yes', please submit chart notes or medical records of endoscopic nasal polyps score*
❒ Yes, *Continue to #192*
❒ No, *Continue to #192*

192. Does the patient have symptoms of nasal blockage, congestion, or obstruction?
❒ Yes, *Continue to #193*
❒ No, *Continue to #193*

193. Does the patient have rhinorrhea (anterior/posterior), reduction or loss of smell, or facial pain or pressure?
❒ Yes, *Continue to #194*
❒ No, *Continue to #194*

194. Will the patient be using a daily intranasal corticosteroid while being treated with Dupixent?
❒ Yes, *No Further Questions*
❒ No, *Continue to #195*

195. Are intranasal corticosteroids contraindicated or not tolerated?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

Eosinophilic Esophagitis

200. Is Dupixent being prescribed by or in consultation with a gastroenterologist or an allergist/immunologist?
❒ Yes, *Continue to #201*
❒ No, *Continue to #201*

201. Is the patient 1 year of age or older?
❒ Yes, *Continue to #202*
❒ No, *Continue to #202*

202. Does the member weigh 15 kg or more?
❒ Yes, *Continue to #203*
❒ No, *Continue to #203*

203. Is the request for continuation of therapy with the requested drug?
❒ Yes, *Continue to #204*
❒ No, *Continue to #215*

204. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?
❒ Yes, *Continue to #215*
❒ No, *Continue to #210*
❒ Unknown, *Continue to #215*

Continuation of Therapy

210. Has the patient achieved or maintained a positive clinical response as evidenced by improvement in signs and symptoms of eosinophilic esophagitis (EoE) (e.g., dysphagia, heartburn, chest pain, emesis)? ***ACTION REQUIRED: If 'Yes', please attach supporting chart notes or medical record documentation of positive clinical response***
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

New Starts

215. What is the patient's age?
❒ 1 year of age to less than 11 years of age, *Continue to #216*
❒ 11 years of age or older, *Continue to #217*

216. Does the patient show clinical manifestations of disease (e.g., vomiting, heartburn, abdominal pain, food refusal, failure to thrive)?
❒ Yes, *Continue to #218*
❒ No, *Continue to #218*

217. Does the patient have a history of an average of at least 2 episodes of dysphagia (with intake of solids) per week?
❒ Yes, *Continue to #218*
❒ No, *Continue to #218*

218. Has the diagnosis been confirmed by esophageal biopsy as characterized by 15 or more intraepithelial esophageal eosinophils per high power field? ***ACTION REQUIRED: If 'Yes', please attach supporting chart notes or medical record documentation of endoscopic biopsy details including esophageal eosinophil count***
❒ Yes, *Continue to #219*
❒ No, *Continue to #219*

219. Has the member had an inadequate treatment response to proton pump inhibitor? ***ACTION REQUIRED: If 'Yes', please attach supporting chart notes, medical records, or claims history of previous medications tried***

❒ Yes, *Continue to #220*
❒ No, *Continue to #220*

220. Has the member had an inadequate response to systemic corticosteroid and/or oral topical corticosteroid therapies (e.g., budesonide, fluticasone [powder or suspension for inhalation] swallowed)? ***ACTION REQUIRED**: **If 'Yes', please attach supporting chart notes, medical records, or claims history of previous medications tried***
❒ Yes, *No Further Questions*
❒ No, *Continue to #221*

221. Are systemic corticosteroids and oral topical therapies (e.g., budesonide, fluticasone [powder or suspension for inhalation] swallowed) contraindicated or not tolerated? ***ACTION REQUIRED**: **If 'Yes', please attach documentation of clinical reason to avoid therapy***
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

Prurigo Nodularis

250. Is the requested drug being prescribed by or in consultation with a dermatologist or allergist/immunologist?
❒ Yes, *Continue to #251*
❒ No, *Continue to #251*

251. Is the patient an adult?
❒ Yes, *Continue to #252*
❒ No, *Continue to #252*

252. Is the request for continuation of therapy with the requested drug?
❒ Yes, *Continue to #253*
❒ No, *Continue to #270*

253. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?
❒ Yes, *Continue to #270*
❒ No, *Continue to #260*
❒ Unknown, *Continue to #270*

Continuation of Therapy

260. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity of prurigo nodularis (e.g., clear or almost clear skin) since starting treatment with the requested drug? ***ACTION REQUIRED**: **Please attach chart notes or medical record documentation supporting positive clinical response***
❒ Yes, *No Further Questions*
❒ No, *Continue to #261*

261. Has the patient achieved or maintained a positive clinical response as evidenced by a reduction in pruritis intensity and improvement in extent and severity of nodular lesions of prurigo nodularis since starting treatment with the requested drug? ***ACTION REQUIRED**: **Please attach chart notes or medical record documentation supporting positive clinical response***
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

New Starts

270.Does the patient have pruritus lasting at least 6 weeks*? **ACTION REQUIRED**: **Please attach chart note(s) or medical record of pruritis symptoms**
❒ Yes, *Continue to #271*
❒ No, *Continue to #271*

271. Does the patient have history or signs of repeated itch-scratch cycle (e.g., scratching, picking, or rubbing)?
❒ Yes, *Continue to #272*
❒ No, *Continue to #272*

272.Does the patient have a minimum of 20 nodular lesions? **ACTION REQUIRED**: **Please attach chart note(s) or medical record of the presence of nodular lesions**
❒ Yes, *Continue to #273*
❒ No, *Continue to #273*

273. Has the patient had an inadequate response to medium to super-high potency topical corticosteroid? **ACTION REQUIRED**: **Please attach supporting chart note(s), medical record, or claims history showing prerequisite therapies including drug name, dosage form and strength, and response to therapy**
❒ Yes, *Continue to #277*
❒ No, *Continue to #274*

274. Has the patient had an inadequate treatment response to topical calcineurin inhibitor? **ACTION REQUIRED**: **Please attach supporting chart note(s), medical record, or claims history showing prerequisite therapies including drug name, dosage form and strength, and response to therapy**
❒ Yes, *No Further Questions*
❒ No, *Continue to #275*

275. Has the patient had an inadequate treatment response to phototherapy (e.g., UVB, PUVA)? **ACTION REQUIRED**: **Please attach supporting chart note(s) or medical record showing response to phototherapy**
❒ Yes, *No Further Questions*
❒ No, *Continue to #276*

276. Has the patient had an inadequate treatment response to pharmacologic treatment with methotrexate or cyclosporine? **ACTION REQUIRED**: **Please attach supporting chart note(s), medical record, or claims history showing prerequisite therapies including drug name, dosage form and strength, and response to therapy**
❒ Yes, *No Further Questions*
❒ No, *Continue to #278*

277. Please indicate the active ingredient, strength, and dosage form of the medium to super-high potency topical steroid that was tried: _____, *No Further Questions*

278. Has the patient had an intolerance or a clinical reason to avoid medium to super-high potency topical corticosteroids? **ACTION REQUIRED**: **Please attach supporting chart note(s) or medical record showing intolerance or clinical reason to avoid medium to super-high potency topical corticosteroids**
❒ Yes, *Continue to #279*
❒ No, *Continue to #280*

279.Has the patient had an intolerance or a clinical reason to avoid topical calcineurin inhibitors? **ACTION REQUIRED**: **Please attach supporting chart note(s) or medical record showing intolerance or clinical reason to avoid topical calcineurin inhibitors**
❒ Yes, *No Further Questions*
❒ No, *Continue to #280*

280. Has the patient had an intolerance to pharmacologic treatment with methotrexate and cyclosporine? ***ACTION REQUIRED****:* ***Please attach supporting chart note(s) or medical record showing intolerance to methotrexate and cyclosporine***
❒ Yes, *No Further Questions*
❒ No, *Continue to #281*

281. Does the patient have a clinical reason to avoid pharmacologic treatment with methotrexate and cyclosporine? ***ACTION REQUIRED****: Please attach supporting chart note(s) or medical record showing the clinical reason to avoid methotrexate and cyclosporine*
❒ Yes, *Continue to #282*
❒ No, *Continue to #282*

282. Please indicate the clinical reason to avoid pharmacologic treatment with methotrexate and cyclosporine
❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *No Further Questions*
❒ Drug interaction, *No Further Questions*
❒ Risk of treatment-related toxicity, *No Further Questions*
❒ Pregnancy or currently planning pregnancy, *No Further Questions*
❒ Breastfeeding, *No Further Questions*
❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *No Further Questions*

❒ Hypersensitivity, *No Further Questions*
❒ History of intolerance or adverse event, *No Further Questions*
❒ Other, *No Further Questions*

Immune checkpoint inhibitor-related toxicity

300. Is the requested drug being prescribed by or in consultation with a dermatologist, hematologist, or oncologist?
❒ Yes, *Continue to #301*
❒ No, *Continue to #301*

301. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to #302*
❒ No, *Continue to #304*

302. Please select the indication:
❒ Severe (G3) pruritis, *Continue to #304*
❒ Moderate (G2) or severe (G3) bullous dermatitis, *Continue to #303*
❒ Other, *No Other Questions*

303. Has the patient achieved or maintained a positive clinical response as evidenced by improvement in signs and symptoms of the condition since starting treatment with the requested drug?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

304. Does the patient have a refractory case of immune-therapy related severe (G3) pruritus?
❒ Yes, *No Further Questions*
❒ No, *Continue to #305*

305. Will the requested medication be used as additional therapy for moderate (G2) or severe (G3) bullous dermatitis?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

APPENDIX: Relative potency of select topical corticosteroid products

Potency	Drug	Dosage form	Strength
I. Super-high potency (group 1)	Augmented betamethasone dipropionate	Ointment, Lotion, Gel	0.05%
	Clobetasol propionate	Cream, Gel, Ointment, Solution, Cream (emollient), Lotion, Shampoo, Foam, Spray	0.05%
	Fluocinonide	Cream	0.1%
	Flurandrenolide	Tape	4 mcg/cm^2
	Halobetasol propionate	Cream, Lotion, Ointment	0.05%
II. High potency (group 2)	Amcinonide	Ointment	0.1%
	Augmented betamethasone dipropionate	Cream	0.05%
	Betamethasone dipropionate	Ointment	0.05%
	Clobetasol propionate	Cream	0.025%
	Desoximetasone	Cream, Ointment, Spray	0.25%
		Gel	0.05%
	Diflorasone diacetate	Ointment, Cream (emollient)	0.05%
	Fluocinonide	Cream, Ointment, Gel, solution	0.05%
	Halcinonide	Cream, Ointment	0.1%
	Halobetasol propionate	Lotion	0.01%
III. High potency (group 3)	Amcinonide	Cream Lotion	0.1%
	Betamethasone dipropionate	Cream, hydrophilic emollient	0.05%
	Betamethasone valerate	Ointment	0.1%
		Foam	0.12%
	Desoximetasone	Cream	0.05%
	Diflorasone diacetate	Cream	0.05%
	Fluocinonide	Cream, aqueous emollient	0.05%
	Fluticasone propionate	Ointment	0.005%
	Mometasone furoate	Ointment	0.1%
	Triamcinolone acetonide	Cream, Ointment	0.5%
IV. Medium potency (group 4)	Betamethasone dipropionate	Spray	0.05%
	Clocortolone pivalate	Cream	0.1%
	Fluocinolone acetonide	Ointment	0.025%
	Flurandrenolide	Ointment	0.05%
	Hydrocortisone valerate	Ointment	0.2%
	Mometasone furoate	Cream, Ointment, Lotion, Solution	0.1%
	Triamcinolone acetonide	Cream	0.1%
		Ointment	0.05% and 0.1%
		Aerosol Spray	0.2 mg per 2-second spray

V. Lower-mid potency (group 5)	Betamethasone dipropionate	Lotion	0.05%
	Betamethasone valerate	Cream	0.1%
	Desonide	Ointment, Gel	0.05%
	Fluocinolone acetonide	Cream	0.025%
	Flurandrenolide	Cream, Lotion	0.05%
	Fluticasone propionate	Cream, Lotion	0.05%
	Hydrocortisone butyrate	Cream, Lotion, Ointment, Solution	0.1%
	Hydrocortisone probutate	Cream	0.1%
	Hydrocortisone valerate	Cream	0.2%
	Prednicarbate	Cream (emollient), Ointment	0.1%
	Triamcinolone acetonide	Lotion	0.1%
		Ointment	0.025%
VI. Low potency (group 6)	Alclometasone dipropionate	Cream, Ointment	0.05%
	Betamethasone valerate	Lotion	0.1%

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**