



SPECIAL AUTHORIZATION REQUEST FORM
The Newfoundland and Labrador Prescription Drug Program (NLPDP)
Request for Coverage for Dupilumab for ATOPIC DERMATITIS

Pharmaceutical Services
 Department of Health and Community Services
 P.O. Box 8700, Confederation Bldg. St. John's, NL A1B 4J6

Phone: (709) 729-6507
 Toll Free Line: 1-888-222-0533
 Fax: (709) 729-2851

Patient Information

Patient Name	Date of Birth	NLPDP Drug Card/MCP Number
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Address

Drug Requested for Special Authorization

Dupixent 150mg/mL PFS Dupixent 200mg/1.14mL PFS Dupixent 300mg single-dose prefilled pen

A - For Initiation

For improving the signs and symptoms of atopic dermatitis in adult patients with moderate-to-severe atopic dermatitis only if the following conditions are met:

1. Patients must have a clinical diagnosis of atopic dermatitis with all of the following characteristics:

- An Investigator's Global Assessment (IGA) score of 3 (moderate) or 4 (severe)
 - Please specify IGA score _____ **Date assessed** _____
- An Eczema Area and Severity Index score of 7.1 or greater
 - Please specify EASI score _____ **Date assessed** _____

2. For use in patients whom have not adequately responded to all of the following: topical therapy, methotrexate, cyclosporine, and phototherapy. Provide details of previous therapy trials below.

Medication	Dose	Date/Duration	Outcome
Methotrexate			<input type="checkbox"/> Refractory <input type="checkbox"/> Intolerant (describe)
Cyclosporine			<input type="checkbox"/> Refractory <input type="checkbox"/> Intolerant (describe)
Phototherapy			<input type="checkbox"/> Refractory <input type="checkbox"/> Intolerant (describe)
Topical Therapy			<input type="checkbox"/> Refractory <input type="checkbox"/> Intolerant (describe)

B - For Renewal

For continued coverage beyond 6 months, the patient must meet the following criteria. Note: This medication is not to be used in combination with phototherapy or immunosuppressant drugs, such as methotrexate or cyclosporine:

The prescriber must confirm, in writing that the patient is a responder as defined as a 75% or greater improvement from baseline in the EASI score (EASI-75).

- Please specify EASI score _____ **Date assessed** _____

Additional Comments:

Prescriber Information / Requested By: Physician Other Health Professional

Prescriber Name: _____ License Number: _____
 (please print)

Address: _____ Phone Number: _____ Fax Number: _____

Signature: _____ Date: _____

Pharmacist Name: _____ Pharmacy Name: _____
 (optional) (optional)