Health Partners Medicare

PRIOR AUTHORIZATION REQUEST FORM

Dupixent - Medicare

Phone: 215-991-4300 Fax back to: 866-371-3239

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Will Dupixent be prescribed by a pulmonologist, allergist, immunologist, dermatologist, otolaryngologist, or gastroenterologist?

☐ Yes ☐ No

Q2. Is the patient 6 months of age or older?

☐ Yes ☐ No

Q3. Is Dupixent being used for moderate-to-severe atopic dermatitis whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable?

☐ Yes ☐ No

Q4. Is the patient 6 years of age or older?

☐ Yes ☐ No

Q5. Is Dupixent being used for add on maintenance therapy for the treatment of moderate to severe asthma with eosinophilic type?

☐ Yes ☐ No

Q6. Is Dupixent being used for add on maintenance therapy for the treatment of oral corticosteroid dependent asthma?

☐ Yes ☐ No

Q7. Is Dupixent being used for add-on maintenance therapy treatment in patients with inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP)?

Health Partners Medicare

PRIOR AUTHORIZATION REQUEST FORM

Dupixent - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**

☐ Yes ☐ No

Q8. Is Dupixent being used for the treatment of adult and pediatric patients aged 12 years and older with eosinophilic esophagitis (EoE)?

☐ Yes ☐ No

Q9. Is Dupixent being used for the treatment of Prurigo nodularis?

☐ Yes ☐ No

Q10. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q11. For patients with moderate-to-severe atopic dermatitis whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable, is there documentation showing that the patient had a trial of, intolerance to, or contraindication to 1 topical corticosteroidand 1 topical calcineurin inhibitor for patients 2 years of age and older OR 1 topical calcineurin inhibitor for patients under the age of 2?

☐ Yes ☐ No

Q12. For add on maintenance therapy for the treatment of moderate to severe asthma with eosinophilic type, is there diagnosis of eosinophilic asthma including eosinophil count equal to or greater than 150 microliters ? Labs must be attached.

☐ Yes ☐ No

Q13. Is there documentation showing that the patient had a trial of, intolerance to, or contraindication to combination therapies (inhaled steroids, long acting beta-agonists, antileukotrienes, theophylline)?

☐ Yes ☐ No

Q14. For add on maintenance therapy for the treatment of oral corticosteroid dependent asthma, is there documentation showing the patient has oral corticosteroid dependent asthma?

☐ Yes ☐ No

Q15. Is there documentation showing that the patient had a trial of, intolerance to, or contraindication to combination therapies (inhaled steroids, long acting beta-agonists, antileukotrienes, theophylline)?

☐ Yes ☐ No

Q16. For add-on maintenance treatment in patients 18 years of age and older with inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP) is there documentation of a diagnosis of chronic rhinosinusitis with nasal polyposis?

☐ Yes ☐ No

Q17. Is there documentation showing that the patient had a trial of, intolerance to, or contraindication to intranasal corticosteroids and trial of, intolerance to, or contraindication to systemic corticosteroid therapy?

Health Partners Medicare

PRIOR AUTHORIZATION REQUEST FORM

Dupixent - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**

☐ Yes	☐ No
Q18. Is there documentation showing that the patient had a trial of, intolerance to, or contraindication to at least one proton pump inhibitor?	
☐ Yes	☐ No
Q19. Is there documentation showing that the patient had a trial of, intolerance to, or contraindication to inhaled fluticasone propionate?	
☐ Yes	☐ No
Q20. Is the patient 18 years of age or older?	
☐ Yes	☐ No
Q21. Is there documentation of a diagnois of Prurigo nodularis?	
☐ Yes	☐ No
Q22. Is there documentation showing that the patient had a trial of, intolerance to, or contraindication to at least one high potency topical steroid?	
☐ Yes	☐ No
Q23. Is there documentation showing that the patient had a trial of, intolerance to, or contraindication to at least one systemic immunosuppressant (such as methotrexate or cyclosporine)?	
☐ Yes	☐ No
Q24. Additional Information:	

_____ _____

Prescriber Signature Date

2023 Medicare Prior Authorization Request