Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Dupixent

Phone: 215-991-4300 **Fax back to: 866-240-3712**

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.

Member Name:	Prescriber Name:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Member Primary Phone:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	
HPP's maximum approval time is 12 months but may be less depending on the drug.		

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. The request is for renewal of a prior authorization for Dupixent (dupilumab) that was previously approved. If YES, go to 20. If NO, go to 2.

☐ Yes ☐ No

Q2. The member is being treated for a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling or a medically accepted indication.

☐ Yes ☐ No

Q3. The member is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

☐ Yes ☐ No

Q4. The member is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

☐ Yes ☐ No

Q5. The member is prescribed Dupixent (dupilumab) by or in consultation with an appropriate specialist (e.g., pulmonologist, allergist, immunologist, dermatologist, hematologist/oncologist, rheumatologist, etc.).

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☐ Yes ☐ No

Q6. If currently using a different Monoclonal Antibody (MAB) - Anti-IL, Anti-IgE, Anti-TSLP, will discontinue the other MAB - Anti-IL, Anti-IgE, Anti-TSLP prior to starting Dupixent (dupilumab).

☐ Yes ☐ No ☐ NA

Q7. If currently using a different targeted systemic Immunomodulators, Dermatologic (e.g., Adbry [tralokinumab], Cibinqo [abrocitinib], Nemluvio [nemolizumab], Rinvoq [upadacitinib]), will discontinue the other targeted systemic Immunomodulators, Dermatologic prior to starting Dupixent (dupilumab).

☐ Yes ☐ No ☐ NA

Q8. For a diagnosis of chronic atopic dermatitis, has atopic dermatitis associated with at least one of the following:

a. A body surface area of 10% or greater that is affected,
b. Involvement of critical areas (e.g., face, feet, genitals, hands, intertriginous areas, scalp),
c. Significant disability or impairment of physical, mental, or psychosocial functioning

☐ Yes ☐ No ☐ NA

Q9. For a diagnosis of chronic atopic dermatitis, has a history of therapeutic failure of or a contraindication or an intolerance to ONE of the following:

a. A four-week trial of a low-potency topical corticosteroid for treatment of the face, skin folds, or other critical areas,
b. For treatment of other areas, a four-week trial of a medium-potency or higher topical corticosteroid.

☐ Yes ☐ No

Q10. For a diagnosis of chronic atopic dermatitis, has a history of therapeutic failure of or a contraindication or an intolerance to an eight-week trial of a topical calcineurin inhibitor.

☐ Yes ☐ No

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Q11. For a diagnosis of asthma, the member has asthma severity consistent with the FDA-approved indication for Dupixent (dupilumab) despite maximal therapeutic doses of or a contraindication or an intolerance to asthma controller drugs based on current national treatment guidelines for the diagnosis and management of asthma.

☐ Yes ☐ No ☐ NA

Q12. For a diagnosis of asthma, ONE of the following:

a. Has an absolute blood eosinophil count 150 cells/microL
b. Is dependent on oral corticosteroids.

☐ Yes ☐ No

Q13. The member will use Dupixent (dupilumab) in addition to standard asthma controller drugs as recommended by current national treatment guidelines.

☐ Yes ☐ No

Q14. For a diagnosis of eosinophilic esophagitis, has a history of therapeutic failure of or a contraindication or an intolerance to a proton pump inhibitor.

☐ Yes ☐ No ☐ NA

Q15. For a diagnosis of prurigo nodularis, the member has a history of pruritis lasting at least six weeks.

☐ Yes ☐ No ☐ NA

Q16. The member has prurigo nodularis associated with at least one of the following:

a. greater than or equal to 20 nodular lesions
b. Significant disability or impairment of physical, mental, or psychosocial functioning;

☐ Yes ☐ No

Q17. For a diagnosis of bullous pemphigoid, ONE of the following:

a. The member has a history of therapeutic failure of or a contraindication or an intolerance to

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systemic corticosteroids
b. Has corticosteroid-dependent disease

☐ Yes ☐ No ☐ NA

Q18. The member meets ONE of the following:

a. Has a history of therapeutic failure of a corticosteroid-sparing therapy (e.g., doxycycline, dapsone, methotrexate, mycophenolate, azathioprine)

b. Has a contraindication or an intolerance to corticosteroid-sparing therapies;

☐ Yes ☐ No

Q19. For all other diagnoses, the member has a history of therapeutic failure of or a contraindication or an intolerance to first line therapy(ies) if applicable according to consensus treatment guidelines.

☐ Yes ☐ No

Q20. The member is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

☐ Yes ☐ No

Q21. The member is prescribed Dupixent (dupilumab) by or in consultation with an appropriate specialist (e.g., pulmonologist, allergist, immunologist, dermatologist, hematologist/oncologist, rheumatologist, etc.).

☐ Yes ☐ No

Q22. The member has documented evidence of improvement in disease severity

☐ Yes ☐ No

Q23. For a diagnosis of asthma, ONE of the following:

a. Has documented measurable evidence of improvement in the severity of the asthma condition
b. Has reduction of oral corticosteroid dose while maintaining asthma control

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☐ Yes ☐ No ☐ NA

Q24. The member continues to use Dupixent (dupilumab) in addition to standard asthma controller drugs as recommended by current national treatment guidelines.

☐ Yes ☐ No

Q25. Additional Information:

_____ _____

Prescriber Signature Date

v2026