HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Immunomodulators - Dermatologics

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 an Immunomodulators, Dermatologic that was previously approved. If YES, go to 24.

☐ Yes ☐ No

Q2. The member meets ALL of the following:

☐ Is prescribed the Immunomodulators Dermatologic for the treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling or a medically accepted indication

☐ Is age-appropriate according to FDA-approved package labeling, national compendia, or peer-reviewed medical literature

☐ Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

☐ Does not have a contraindication to the requested drug

Q3. What type of drug is being requested?

☐ For a non-preferred topical calcineurin inhibitor, go to 4.
☐ For a topical PDE4 inhibitor (e.g., crisaborole, roflumilast), go to 5.
☐ For a topical JAK inhibitor (e.g., ruxolitinib), go to 8.
☐ For a topical AhR agonist (e.g., tapinarof), go to 11.

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☐ For all other non-preferred topical Immunomodulators, Dermatologics, go to 15.
☐ For a targeted systemic Immunomodulators, Dermatologic, go to 16

Q4. For a non-preferred topical calcineurin inhibitor, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred topical calcineurin inhibitors.

☐ Yes ☐ No

Q5. For a topical PDE4 inhibitor (e.g., crisaborole, roflumilast), for treatment of atopic dermatitis, has a history of therapeutic failure of or a contraindication or an intolerance to both of the following:

☐ A four-week trial of a topical corticosteroid approved or medically accepted for the treatment of the beneficiary's diagnosis

☐ An eight-week trial of a topical calcineurin inhibitor approved or medically accepted for the treatment of the beneficiary's diagnosis.

Q6. For a topical PDE4 inhibitor (e.g., crisaborole, roflumilast), for treatment of all other diagnoses, 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

Q7. For a non-preferred topical PDE4 inhibitor, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred topical PDE4 inhibitors approved or medically accepted for the beneficiary's diagnosis. Describe all applicable medical reasons the beneficiary cannot use the preferred medication(s) in the same class. Submit documentation (e.g., recent chart/clinic notes, diagnostic evaluations, lab results, etc.) supporting this non-preferred request. Include drug name, dose, and start/stop dates.

☐ Yes ☐ No

Q8. For a topical JAK inhibitor (e.g., ruxolitinib), for treatment of atopic dermatitis, chronic hand eczema, or vitiligo, has a history of therapeutic failure of or a contraindication or an intolerance to both of the following:

☐ A four-week trial of a topical corticosteroid approved or medically accepted for the treatment of the beneficiary's diagnosis

☐ An eight-week trial of a topical calcineurin inhibitor approved or medically accepted for the treatment of the beneficiary's diagnosis.

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Q9. For a topical JAK inhibitor (e.g., ruxolitinib), for treatment of all other diagnoses, 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

Q10. For a non-preferred topical JAK inhibitor, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred topical JAK inhibitors approved or medically accepted for the beneficiary's diagnosis

☐ Yes ☐ No

Q11. For a topical AhR agonist (e.g., tapinarof), for treatment of atopic dermatitis, has a history of therapeutic failure of or a contraindication or an intolerance to both of the following:

☐ A four-week trial of a topical corticosteroid approved or medically accepted for the treatment of the beneficiary's diagnosis

☐ An eight-week trial of a topical calcineurin inhibitor approved or medically accepted for the treatment of the beneficiary's diagnosis.

Q12. For treatment of psoriasis, see the prior authorization guideline for Antipsoriatics, Topical. For treatment of all other diagnoses, go to 13.

☐ Yes ☐ No

Q13. For treatment of all other diagnoses, 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

Q14. For a non-preferred topical AhR agonist, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred topical AhR agonists approved or medically accepted for the beneficiary's diagnosis.

☐ Yes ☐ No

Q15. For all other non-preferred topical Immunomodulators, Dermatologics, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred topical Immunomodulators, Dermatologics approved or medically accepted for the beneficiary's diagnosis. Describe all applicable medical reasons the beneficiary cannot use the preferred

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medication(s) in the same class. Submit documentation (e.g., recent chart/clinic notes, diagnostic evaluations, lab results, etc.) supporting this non-preferred request. Include drug name, dose, and start/stop dates.

☐ Yes ☐ No

Q16. For a targeted systemic Immunomodulators, Dermatologic, all of the following:

☐ Is prescribed the targeted systemic Immunomodulators, Dermatologic by or in consultation with an appropriate specialist (e.g., dermatologist).

☐ If currently using a different targeted systemic Immunomodulators, Dermatologic, will discontinue the other targeted systemic Immunomodulators, Dermatologic prior to starting the requested targeted systemic Immunomodulators, Dermatologic.

Q17. For treatment of chronic atopic dermatitis, has atopic dermatitis associated with at least one of the following:

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

Q18. The member has a history of therapeutic failure of or a contraindication or an intolerance to both of the following:

☐ A four-week trial of a topical corticosteroid approved or medically accepted for the treatment of the beneficiary's diagnosis

☐ An eight-week trial of a topical calcineurin inhibitor approved or medically accepted for the treatment of the beneficiary's diagnosis

Q19. For treatment of prurigo nodularis, has a history of pruritis lasting at least six weeks.

☐ Yes ☐ No

Q20. The member has prurigo nodularis associated with at least one of the following:

☐ Greater than or equal to 20 nodular lesions

☐ Significant disability or impairment of physical, mental, or psychosocial functioning

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Q21. For treatment of 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 current consensus treatment guidelines.

☐ Yes ☐ No

Q22. For an oral JAK inhibitor, the member meets one of the following:

☐ Has a history of therapeutic failure of at least one biologic if recommended for the beneficiary's diagnosis in the FDA-approved package labeling for the requested oral JAK inhibitor

☐ Has a contraindication or an intolerance to biologics if recommended for the beneficiary's diagnosis in the FDA-approved package labeling for the requested oral JAK inhibitor

☐ Has a current history (within the past 90 days) of being prescribed an oral JAK inhibitor

Q23. For a non-preferred targeted systemic Immunomodulators, Dermatologic, one of the following:

☐ Has a history of therapeutic failure of or a contraindication or an intolerance to the preferred targeted systemic Immunomodulators, Dermatologics approved or medically accepted for the beneficiary's diagnosis

☐ Has a current history (within the past 90 days) of being prescribed the same targeted systemic Immunomodulators, Dermatologic (does not apply to non-preferred targeted systemic Immunomodulators, Dermatologics when a therapeutically equivalent brand/generic or corresponding biosimilar/brand biologic/unbranded biologic is preferred)

Q24. The member has documented evidence of improvement of disease severity.

☐ Yes ☐ No

Q25. The member is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

☐ Yes ☐ No

Q26. The member does not have a contraindication to the requested drug.

☐ Yes ☐ No

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Q27. The request is for a PREFERRED topical PDE4 inhibitor, topical JAK inhibitor, topical AhR agonist

☐ Yes ☐ No

Q28. What type of drug is being requested?

☐ For a non-preferred topical calcineurin inhibitor, go to 29.
☐ For a non-preferred topical PDE4 inhibitor (e.g., crisaborole, roflumilast), go to 30.
☐ For a non-preferred topical JAK inhibitor (e.g., ruxolitinib), go to 31.
☐ For a non-preferred topical AhR agonist (e.g., tapinarof), go to 32.
☐ For all other non-preferred topical Immunomodulators, Dermatologics, go to 33.
☐ For a targeted systemic Immunomodulators, Dermatologic, go to 34.

Q29. For a non-preferred topical calcineurin inhibitor, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred topical calcineurin inhibitors.

☐ Yes ☐ No

Q30. For a non-preferred topical PDE4 inhibitor, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred topical PDE4 inhibitors approved or medically accepted for the beneficiary's diagnosis.

☐ Yes ☐ No

Q31. For a non-preferred topical JAK inhibitor, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred topical JAK inhibitors approved or medically accepted for the beneficiary's diagnosis.

☐ Yes ☐ No

Q32. For a non-preferred topical AhR agonist, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred topical AhR agonists approved or medically accepted for the beneficiary's diagnosis.

☐ Yes ☐ No

Q33. For all other non-preferred topical Immunomodulators, Dermatologics, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred topical

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Immunomodulators, Dermatologics approved or medically accepted for the beneficiary's diagnosis.

☐ Yes ☐ No

Q34. For a targeted systemic Immunomodulator, Dermatologics, both of the following:

☐ Is prescribed the targeted systemic Immunomodulators, Dermatologic by or in consultation with an appropriate specialist (e.g., dermatologist)

☐ For a non-preferred targeted systemic Immunomodulators, Dermatologic with a therapeutically equivalent brand/generic or corresponding biosimilar/brand biologic/unbranded biologic that is preferred on the PDL, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred therapeutically equivalent brand/generic or corresponding biosimilar/brand biologic/unbranded biologic that would not be expected to occur with the requested drug.

Q35. Additional Information:

Prescriber Signature

Date

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