



**MEDICARE ADVANTAGE  
PRIOR AUTHORIZATION REQUEST FORM**

Dupixent

Phone: 215-991-4300

Fax back to: 866-371-3239

Jefferson Health 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.**

<b>Member Name:</b>	<b>Prescriber Name:</b>	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: <input type="checkbox"/> Medicare Advantage	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	<b>Specialty/facility name (if applicable):</b>	

**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. Is this a reauthorization request?

Yes

No

Q2. For reauthorization: Has the prescriber provided confirmation of a positive clinical response?

Yes

No

Q3. Will Dupixent be prescribed by or in consultation with a pulmonologist, allergist, immunologist, dermatologist, otolaryngologist, or gastroenterologist?

Yes

No

Q4. 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? If YES, go to question 13.

Yes

No

Q5. Is Dupixent being used for add on maintenance therapy for the treatment of moderate to severe asthma with eosinophilic type. If YES, go to question 14.



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<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q6. Is Dupixent being used for add on maintenance therapy for the treatment of oral corticosteroid dependent asthma? If YES, go to question 16.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q7. Is Dupixent being used for add-on maintenance therapy treatment in patients with inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP). If YES, go to question 18.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q8. Is Dupixent being used for the treatment eosinophilic esophagitis (EoE)? If YES go to 21.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. Is Dupixent being used for the treatment of prurigo nodularis? If YES, go to 24.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q10. Is Dupixent being used as add-on maintenance treatment of adult patients with inadequately controlled chronic obstructive pulmonary disease (COPD) and an eosinophilic phenotype? If YES go to 25.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q11. Is Dupixent being used for chronic spontaneous urticaria (CSU) in patients who remain symptomatic despite H1 antihistamine treatment? If YES go to 29.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q12. Is Dupixent being used for the treatment of bullous pemphigoid (BP)? If YES, go to 32.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q13. 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 of inadequate response, intolerance, or contraindication to at least one topical	



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corticosteroid and at least one topical calcineurin inhibitor for patients 2 years of age and older OR at least one topical steroid for patients under the age of 2?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q14. 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.	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q15. Is there documentation showing that the patient had inadequate response, intolerance, or contraindication to both of the following medications: 1) medium-to-high-dose inhaled corticosteroid, AND 2) additional controller (i.e., LABA, LAMA, leukotriene modifier, or theophylline)?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q16. For add on maintenance therapy for the treatment of oral corticosteroid dependent asthma, is there documentation showing the patient has oral corticosteroid dependent asthma?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q17. Is there documentation showing that the patient had inadequate response, intolerance, or contraindication to both of the following medications: 1) high-dose inhaled corticosteroid AND 2) additional controller (i.e., long acting beta2-agonist (LABA), long-acting muscarinic antagonist (LAMA), leukotriene modifier, or theophylline)?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q18. For add-on maintenance treatment in patients with inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP) is there documentation of a diagnosis of chronic rhinosinusitis with nasal polyposis?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q19. Is there documentation showing that the patient had inadequate response, intolerance, or contraindication to at least one intranasal corticosteroid?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	

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Q20. Is there documentation showing that the patient had inadequate response, intolerance, or contraindication to at least one systemic corticosteroid therapy?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q21. Is there documentation of a diagnosis of eosinophilic esophagitis?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q22. Is there documentation showing that the patient had inadequate response, intolerance, or contraindication to at least one proton pump inhibitor?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q23. Is there documentation showing that the patient had inadequate response, intolerance, or contraindication to one topical corticosteroid (swallowed inhaled fluticasone propionate, swallowed budesonide)?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q24. Is there documentation of a diagnosis of prurigo nodularis?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q25. Is there documentation showing a diagnosis of COPD with an eosinophilic phenotype including eosinophil count greater than 300 cells/microL (lab results required)?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q26. Is there documentation showing the patient's COPD is inadequately controlled?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q27. Is there documentation showing inadequate response, intolerance, or contraindication to at least one inhaled combination therapy (including LAMA/LABA or LAMA/LABA/ICS combination therapies)?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	



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Q28. Is there documentation showing inadequate response, intolerance, or contraindication to chronic azithromycin therapy or roflumilast?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q29. Does the patient have a diagnosis of chronic spontaneous urticaria (CSU)?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q30. Are there chart notes confirming that other forms of urticaria have been ruled out?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q31. Is there documentation showing inadequate response, intolerance, or contraindication to at least one H1 antihistamine treatment?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q32. Is there documentation of a diagnosis of bullous pemphigoid?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q33. Is there documentation of inadequate response, contraindication, or intolerance to one systemic corticosteroid OR documentation of inadequate response, contraindication, or intolerance to one immunosuppressive agent (i.e., azathioprine, cyclophosphamide, mycophenolate mofetil)?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q34. Requested Duration:	
<input type="checkbox"/> 12 Months	<input type="checkbox"/> Other:
Q35. Additional Information:	

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date



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