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.

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

□ Expedited/Urgent

Drug Name:
Strength:
Days Supply:
Number of Refills:
Directions / SIG:

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. Is Dupixent being prescribed by or in consultation with a dermatologist?

☐ Yes ☐ No

Q2. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q3. Does the patient have a diagnosis of moderate to severe atopic dermatitis with at least one of the following? a. Involvement of at least 10% of body surface area (BSA); OR; B. Eczema Area and Severity Index (EASI) score of 16 or greater; OR ; C. Investigator's Global Assessment (IGA) score of 3 or more; OR ; D. Scoring Atopic Dermatitis (SCORAD) score of 20 or more

☐ Yes ☐ No

Q4. Has the patient tried and failed, or has a contraindication or intolerance to the following formulary topical agents? (Please include documentation of agents used, with dose/strength, dates/duration of use, and specific outcomes.) A. Topical corticosteroids; AND B. Topical tacrolimus ointment (Please note, topical tacrolimus ointment requires a prior authorization.)

☐ Yes ☐ No

Q5. Has documentation been attached showing that the patient will not receive live vaccines during therapy?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q6. Requested Duration:

☐ 6 months

Prescriber Signature

Date

Updated 2018