



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Dupixent Renewal

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.

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

Expedited/Urgent checkbox

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. Has the patient been previously approved for Dupixent?

Yes checkbox

No checkbox

Q2. Has the patient been compliant with receiving Dupixent ?

Yes checkbox

No checkbox

Q3. Has documentation of improvement in symptoms compared to baseline in one or more of the following: pruritus, the amount of surface area involvement, Eczema Area and Severity Index (EASI), Investigator's Global Assessment (IGA), and/or Scoring Atopic Dermatitis (SCORAD) been attached?

Yes checkbox

No checkbox

Q4. Has the patient been tolerating Dupixent without any significant side effects?

Yes checkbox

No checkbox

Q5. Requested Duration:

12 months checkbox

Prescriber Signature

Date

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Prescriber Name:

Updated 2018