Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

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.

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. Has the patient been previously approved for Dupixent?

☐ Yes ☐ No

Q2. Has the patient been compliant with receiving Dupixent ?

☐ Yes ☐ No

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 ☐ No

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

☐ Yes ☐ No

Q5. Requested Duration:

☐ 12 months

Prescriber Signature

Date

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