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:	
Patient 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. Is this request for renewal of therapy (e.g., Dupixent has been previously approved on prior authorization)? [If yes, skip to question 20.]

☐ Yes ☐ No

Q2. Does the patient have a diagnosis that is indicated in the United States Food and Drug Administration (FDA)-approved package labeling or a medically accepted indication?

☐ Yes ☐ No

Q3. Is the prescribed dose consistent with Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia or peer-reviewed medical literature?

☐ Yes ☐ No

Q4. Is Dupixent being prescribed by or in consultation with an appropriate specialist (e.g., dermatologist, immunologist, allergist, pulmonologist, otolaryngologist, etc)?

☐ Yes ☐ No

Q5. Will the patient be evaluated, treated and/or monitored for parasitic (helminth) infection before and/or during treatment with Dupixent as recommended in Food and Drug Administration (FDA)-approved package labeling?

☐ Yes ☐ No

Q6. Will Dupixent be used in combination with another monoclonal antibody (anti-IL, anti-IgE)?

☐ Yes ☐ No

Q7. Does the patient have a diagnosis of chronic moderate-to-severe atopic dermatitis?

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:

☐ Yes ☐ No

Q8. Does the patient have a documented history of therapeutic failure, contraindication or intolerance to one of the following topical pharmacologic treatments: A) Low-potency topical corticosteroids (for treatment of the face or skin folds), B) Medium-to-high potency topical corticosteroids (for treatment of areas other than the face and skin folds), C) Topical calcineurin inhibitors? Note: Please attach documentation.

☐ Yes ☐ No

Q9. Does the patient have documented therapeutic failure, contraindication or intolerance to phototherapy in accordance with current consensus guidelines? Note: Please attach documentation.

☐ Yes ☐ No

Q10. Does the patient have documented therapeutic failure, contraindication or intolerance to systemic immunosuppressives in accordance with current consensus guidelines (e.g., cyclosporine, azathioprine, methotrexate, mycophenolate mofetil)? Note: Please attach documentation.
[If yes, skip to question 18.]

☐ Yes ☐ No

Q11. Does the patient have a diagnosis of asthma?

☐ Yes ☐ No

Q12. Is the patient's asthma severity consistent with the Food and Drug Administration (FDA)-approved indication for Dupixent despite maximal therapeutic doses of or intolerance or contraindication to asthma controller medications based on current national treatment guidelines for the diagnosis and management of asthma?

☐ Yes ☐ No

Q13. Will Dupixent be used in addition to standard asthma controller medications as recommended by current national treatment guidelines?

☐ Yes ☐ No

Q14. Does the patient have eosinophilic asthma?

☐ Yes ☐ No

Q15. Is the absolute blood eosinophil count at least 150 cells per microliter?
[If yes, skip to question 18.]

☐ Yes ☐ No

Q16. Does the patient have a diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP)?

☐ Yes ☐ No

Q17. Does the patient have a documented history or therapeutic failure, contraindication or intolerance to all of the

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:

following: A) at least a 14 day course of systemic glucocorticoids, B) Sino-nasal surgery, C) Maintenance nebulized or irrigated intranasal glucocorticoids? Note: Please attach documentation.

☐ Yes ☐ No

Q18. Does the patient have a history of therapeutic failure, contraindication or intolerance to the preferred agents approved for the indication?

☐ Yes ☐ No

Q19. Does the patient have a current history (within the past 90 days) of being prescribed Dupixent?

☐ Yes ☐ No

Q20. Is the prescribed dose consistent with Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia or peer-reviewed medical literature?

☐ Yes ☐ No

Q21. Is Dupixent being prescribed by or in consultation with an appropriate specialist (e.g., dermatologist, immunologist, allergist, pulmonologist, otolaryngologist, etc)?

☐ Yes ☐ No

Q22. Is the patient being monitored or treated, if applicable, for parasitic (helminth) infection as recommended in Food and Drug Administration (FDA)-approved package labeling?

☐ Yes ☐ No

Q23. Will Dupixent be used in combination with another monoclonal antibody (anti-IL, anti-IgE)?

☐ Yes ☐ No

Q24. Does the patient have a diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP) or atopic dermatitis?

☐ Yes ☐ No

Q25. Has the patient achieved improvement in disease severity? Note: Please attach documentation of improvement.

☐ Yes ☐ No

Q26. Does the patient have a diagnosis of asthma?

☐ Yes ☐ No

Q27. Has there been documented measurable evidence of improvement in the severity of the asthma condition since initiating therapy with Dupixent?

☐ Yes ☐ No

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:

Q28. Since initiating therapy with Dupixent, has the patient been able to reduce the dose of oral corticosteroids while maintaining asthma control?

☐ Yes ☐ No

Q29. Is the patient using Dupixent in addition to standard asthma controller medications as recommended by current national treatment guidelines?

☐ Yes ☐ No

Q30. Additional Information:

Prescriber Signature

Date

Updated for 2020