



2024 PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Dupixent
Fax back to: (833) 605-4407
Phone: (215) 991-4300

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.

Form with fields: Patient Name, Prescriber Name, Member Number, Fax, Phone, Date of Birth, Office Contact, Line of Business, NPI, State Lic ID, Address, City, State ZIP, Primary Phone, Specialty/facility name (if applicable).

REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Form with fields: 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 renewal request? If yes, go to 2. If no, go to 3.

Yes No

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

Yes No

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

Yes No

Q4. Is the patient 6 months of age or older?

Yes No

Q5. 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?



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Patient Name:	Prescriber Name:
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q6. Is the patient 6 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q7. Is Dupixent being used for add on maintenance therapy for the treatment of moderate to severe asthma with eosinophilic type? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q8. Is Dupixent being used for add on maintenance therapy for the treatment of oral corticosteroid dependent asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q9. Is Dupixent being used for add-on maintenance therapy treatment in patients with inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q10. Is Dupixent being used for the treatment of adult and pediatric patients aged 12 years and older with eosinophilic esophagitis (EoE)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q11. Is Dupixent being used for the treatment of Prurigo nodularis? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q12. Is the patient 18 years of age or older? <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 showing that the patient had a trial of, intolerance to, or contraindication to at	



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least one topical 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 a trial of, intolerance to, or contraindication to at least one combination therapy (inhaled steroids, long acting beta-agonists, antileukotrienes, 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 a trial of, intolerance to, or contraindication to at least one combination therapy (inhaled steroids, long acting beta-agonists, antileukotrienes, 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 a trial of, intolerance to, or contraindication to at least one systemic corticosteroid therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	



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Patient Name:	Prescriber Name:
Q20. Is there documentation showing that the patient had a trial of, intolerance to, or contraindication to at least one intranasal corticosteroid? <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 a trial of, intolerance to, 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 a trial of, intolerance to, or contraindication to inhaled fluticasone propionate? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q24. Is the patient 18 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q25. Is there documentation of a diagnosis of Prurigo nodularis? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q26. Is there documentation showing that the patient had a trial of, intolerance to, or contraindication to at least one high potency topical steroid? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q27. Additional Information:	

Prescriber Signature

Date

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Patient Name:	Prescriber Name:
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2024 Prior Authorization Request