Health Partners Medicare

PRIOR AUTHORIZATION REQUEST FORM

Dupixent - Medicare

Phone: 215-991-4300 Fax back to: 866-371-3239

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:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

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

☐ Yes ☐ No

Q2. Is the patient 6 years of age or older?

☐ Yes ☐ No

Q3. 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?

☐ Yes ☐ No

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

☐ Yes ☐ No

Q5. Is Dupixent being used for add on maintenance therapy for the treatment of moderate to severe asthma with eosinophilic type?

☐ Yes ☐ No

Q6. Is Dupixent being used for add on maintenance therapy for the treatment of oral corticosteroid dependent asthma?

☐ Yes ☐ No

Q7. Is Dupixent being used for add-on maintenance therapy treatment in patients with inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP)?

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☐ Yes ☐ No

Q8. Is Dupixent being used for the treatment of adult and pediatric patients aged 12 years and older with eosinophilic esophagitis (EoE)?

☐ Yes ☐ No

Q9. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q10. 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 topical corticosteroids and topical calcineurin inhibitors (such as tacrolimus ointment).?

☐ Yes ☐ No

Q11. 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.

☐ Yes ☐ No

Q12. Is there documentation showing that the patient had a trial of, intolerance to, or contraindication to combination therapies (inhaled steroids, long-acting beta-agonists, antileukotrienes, or theophylline)?

☐ Yes ☐ No

Q13. For add on maintenance therapy for the treatment of oral corticosteroid dependent asthma, is there documentation showing the patient has oral corticosteroid dependent asthma?

☐ Yes ☐ No

Q14. Is there documentation showing that the patient had a trial of, intolerance to, or contraindication to combination therapies (inhaled steroids, long acting beta-agonists, antileukotrienes, theophylline)?

☐ Yes ☐ No

Q15. For the add-on maintenance therapy treatment in patients 18 years of age and older with inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP), is there documentation of a diagnosis of chronic rhinosinusitis with nasal polyposis?

☐ Yes ☐ No

Q16. Is there documentation showing that the patient had a trial of, intolerance to, or contraindication to intranasal corticosteroids and trial of, intolerance to, or contraindication to systemic corticosteroid therapy?

☐ Yes ☐ No

Q17. Is there documentation showing that the patient had a trial of, intolerance to, or contraindication to at least one

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proton pump inhibitor?

☐ Yes ☐ No

Q18. Is there documentation showing that the patient had a trial of, intolerance to, or contraindication to inhaled fluticasone propionate?

☐ Yes ☐ No

Q19. Requested Duration:

☐ 12 Months

Q20. Additional Information:

Prescriber Signature

Date

2022 Medicare Prior Authorization Request