Health Partners
A part of Jefferson Health Plans

HEALTH PARTNERS PLANS
2024 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 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, go to Q20. If no, go to Q2.

☐ Yes ☐ No

Q2. Does the patient have a diagnosis that is indicated in the United States Food and Drug Administration (FDA)approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ 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., pulmonologist, allergist, immunologist, dermatologist, hematologist/oncologist, rheumatologist, etc.)?

☐ Yes ☐ No

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Q5. If currently using a different Monoclonal Antibody (MAB) – Anti-IL, Anti-IgE, Anti-TSLP, will discontinue the other MAB – Anti-IL, Anti-IgE, Anti-TSLP, prior to starting Dupixent (dupilumab)?

☐ Yes ☐ No

Q6. If currently using a different targeted systemic Immunomodulator, Atopic Dermatitis (e.g., Adbry [tralokinumab], Cibinqo [abrocitinib], Rinvoq [upadacitinib]), will discontinue the other targeted systemic Immunomodulator, Atopic Dermatitis prior to starting Dupixent (dupilumab)?

☐ Yes ☐ No

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

☐ Yes ☐ No

Q8. Does the patient have a history of therapeutic failure of or a contraindication or an intolerance to both of the following?

☐ One of the following: for treatment of the face, skin folds, or other critical areas, a 4-week trial of a low-potency topical corticosteroid. For the treatment of other areas, a 4-week trial of a mediumpotency or higher topical corticosteroid.

☐ An 8-week trial of a topical calcineurin inhibitor.

Q9. Does the patient have a diagnosis of asthma?

☐ Yes ☐ No

Q10. 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

Q11. Is the absolute blood eosinophil count at least 150 cells per microliter?

☐ Yes ☐ No

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Patient Name:	Prescriber Name:

Q12. Is the patient dependent on oral corticosteroids?

☐ 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 a diagnosis of eosinophilic esophagitis?

☐ Yes ☐ No

Q15. Does the patient have documented therapeutic failure, contraindication, or intolerance to a proton pump inhibitor?

☐ Yes ☐ No

Q16. Does the patient have a diagnosis of prurigo nodularis?

☐ Yes ☐ No

Q17. Has the patient had symptoms of prurigo nodularis for at least 6 weeks?

☐ Yes ☐ No

Q18. Does the patient have prurigo nodularis with at least one of the following:

a.)>20 nodular lesions

b.) significant disability or impairment of physical, mental, or psychosocial functioning

☐ Yes ☐ No

Q19. For all other diagnoses, has a history of therapeutic failure of or a contraindication or an intolerance to first line therapy(ies) if applicable according to consensus treatment guidelines?

☐ Yes ☐ No

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Patient Name:	Prescriber Name:

Q20. Has the patient achieved improvement in disease severity? Please attach documentation of improvement

☐ Yes ☐ No

Q21. Does the patient have a diagnosis of asthma?

☐ Yes ☐ No

Q22. Has there been documented measurable evidence of improvement in the severity of the asthma condition since initiating therapy with Dupixent?

☐ Yes ☐ No

Q23. Since initiating therapy with Dupixent, has the patient been able to reduce the dose of oral corticosteroids while maintaining asthma control?

☐ Yes ☐ No

Q24. Is the patient using Dupixent in addition to standard asthma controller medications as recommended by current national treatment guidelines?

☐ Yes ☐ No

Q25. Additional Information:

Prescriber Signature

Date

Updated for 2024