UnitedHealthcare Community Plan

Prior Authorization Request Form
Fax Back To: (866) 940-7328
Phone: (800) 310-6826

Specialty Medication Prior Authorization Cover Sheet

(This cover sheet should be submitted along with a Pharmacy Prior Authorization Medication Fax Request Form. Please refer to www.uhcprovider.com for medication fax request forms.)

Patient Information

Patient's Name:

Insurance ID: Date of Birth: Height: Weight:

Address: Apartment #:

City: State: Zip Code:

Phone Number: Alternate Phone: Sex: ☐ Male ☐ Female

Provider Information

Provider's Name: Provider ID Number:

Address: City: State: Zip Code:

Suite Number: Building Number:

Phone Number: Fax number:

Provider's Specialty:

Medication Information

Medication: Quantity: ICD10 Code:

Directions: Diagnosis: Refills:

Physician Signature**: Initial here if DAW:

Physician Signature**: By signing above, the physician is providing the specialty pharmacy with a prescription that can be used to facilitate the dispensing and/or coordination of delivery for the requested medication.

Medication Instructions

Has the patient been instructed on how to **Self-Administer**? ☐ Yes ☐ No

Is this medication a **New Start**? ☐ Yes ☐ No

If continuation please provide the following: Initiation Date: / / Date of Last Dose: / /

Is there documentation of positive clinical response to current therapy? ☐ Yes ☐ No

****Please attach any pertinent clinical information that would pertain to support stated diagnosis. Additional clinical information may be needed depending on your patients plan, including medication(s) previously tried and failed.**

Delivery Instructions

Note: Delivery coordination requires a "**Physician Signature**" above and complete "**Provider Information**" and "**Patient Information**"

Note: All necessary ancillary supplies are provided free of charge to the patient at the time of delivery

Ship to: Physician's Office ☐ Patient's Address ☐ Date medication is needed: / /

Medication Administered: Home Health ☐ Self-Administered ☐ LTC ☐ Physician's Office ☐

UnitedHealthcare Community Plan

Dupixent - Pennsylvania

PRIOR AUTHORIZATION REQUEST FORM

Please complete this entire form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**

This form contains multiple pages. Please complete all pages to avoid a delay in our decision.

Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information:		

Is the requested medication □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

UnitedHealthcare Community Plan

Dupixent - Pennsylvania

PRIOR AUTHORIZATION REQUEST FORM

Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

	ALL REQUESTS
□ **Yes** □ **No**	**Does the patient have one of the following diagnoses?** *(If yes, check which applies)* □ Asthma □ Chronic moderate-to-severe atopic dermatitis
□ **Yes** □ **No**	**Is Dupixent prescribed by or in consultation with an appropriate specialist (e.g., dermatologist, immunologist, allergist, pulmonologist, otolaryngologist, etc.)?**
□ **Yes** □ **No**	**Will the patient be evaluated, treated, and/or monitored for parasitic (helminth) infection before and/or during treatment with Dupixent (dupilumab) as recommended in FDA (Food and Drug Administration)-approved package labeling?**
□ **Yes** □ **No**	**Does the patient have a history of therapeutic failure, contraindication, or intolerance to systemic immunosuppressives in accordance with current consensus guidelines (e.g., cyclosporine, azathioprine, methotrexate, mycophenolate mofetil)?** *(If yes, complete Section D above)*
□ **Yes** □ **No**	**Does the patient have a history of therapeutic failure, contraindication, or intolerance of the preferred agents approved for the indication?** *(If yes, complete Section D above)*
□ **Yes** □ **No**	**Does the patient have a current history (within the past 90 days) of being prescribed Dupixent (dupilumab)?**
	ASTHMA
□ **Yes** □ **No**	**Does the patient have asthma severity consistent with the FDA-approved indication for Dupixent (dupilumab) 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?** *(If yes, complete Section D above)*
□ **Yes** □ **No**	**If an eosinophilic phenotype, does the patient have absolute blood eosinophil count greater than or equal to 150 cells/microL?**
□ **Yes** □ **No**	**Will the patient use Dupixent (dupilumab) in addition to standard asthma controller medications as recommended by current national treatment guidelines?**
	CHRONIC MODERATE-TO-SEVERE ATOPIC DERMATITIS
□ **Yes** □ **No**	**Does the patient have documented history of therapeutic failure, contraindication, or intolerance to any of the following topical pharmacologic treatments?** *(If yes, check which applies and complete Section D above)* □ For treatment of the face or skin folds, low-potency topical corticosteroids □ For treatment of areas other than the face or skin folds, medium- to high-potency topical corticosteroids □ Topical calcineurin inhibitors
□ **Yes** □ **No**	**Does the patient have a documented history of therapeutic failure, contraindication, or intolerance to phototherapy in accordance with current consensus guidelines?** *(If yes, complete Section D above)*
	CONTINUATION OF THERAPY - ASTHMA
□ **Yes** □ **No**	**Does the patient have documented measurable evidence of improvement in the severity of the asthma condition?**
□ **Yes** □ **No**	**Does the patient have reduction of oral corticosteroid dose while maintaining asthma control?**
□ **Yes** □ **No**	**Does the patient continue to use Dupixent (dupilumab) in addition to standard asthma controller medications as recommended by current national treatment guidelines?**
	CONTINUATION OF THERAPY - CHRONIC MODERATE-TO-SEVERE ATOPIC DERMATITIS
□ **Yes** □ **No**	**Does the patient have documented evidence of improvement in disease severity?**

Physician Signature: _____ **Date:** _____