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 may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Member Information			Prescriber Information		
Member Name:			Provider Name:		
Member ID:			NPI #:	Specialty:	
Date Of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	ZIP Code:	Office Street Address:		
Phone:	Allergies:		City:	State:	ZIP Code:

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

Medication Information

Medication:	**Strength:**
Directions for use:	**Quantity:**

Medication Administered: ☐ Self-Administered ☐ Physician's Office ☐ Other: _____

Clinical Information

What is the patient's diagnosis for the medication being requested? _____

_____

ICD-10 Code(s): _____

Are there any supporting laboratory or test results related to the patient's diagnosis*? (Please specify or provide documentation)*

Previous Medication Trials / Contraindications

Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

What medication(s) does the patient have a history of failure to? *(Please specify ALL medication(s)/strengths tried, directions, length of trial, and reason for discontinuation of each medication)*

What medication(s) does the patient have a contraindication or intolerance to? *(Please specify ALL medication(s) with the associated contraindication to or specific issues resulting in intolerance to each medication)*

Additional information that may be important for this review

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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 □ Chronic rhinosinusitis with nasal polyposis
□ **Yes** □ **No**	**Will Dupixent be used in combination with another Monoclonal Antibody [Anti-IL (interleukin), Anti-IgE (immunoglobulin E)]?**
	ASTHMA
□ **Yes** □ **No**	**Is Dupixent prescribed by or in consultation with an appropriate specialist (e.g., allergist, immunologist, pulmonologist)?**
□ **Yes** □ **No**	**Does the patient have asthma severity consistent with the 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**	**Does the patient have an absolute blood eosinophil count greater than or equal to 150 cells per microliter?**
□ **Yes** □ **No**	**Is the patient dependent on corticosteroids?**
□ **Yes** □ **No**	**Will Dupixent be used 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 a history of <u>therapeutic failure</u> to any of the following?** *(If yes, check which applies and complete "Previous Medication Trials/Contraindications" section on first page)* □ Low-potency topical corticosteroid (for treatment of the face, skin folds, or other critical areas) OR medium-potency or higher topical corticosteroid (for treatment of other areas) □ Phototherapy in accordance with current consensus guidelines □ Systemic immunosuppressives in accordance with current consensus guidelines (e.g., cyclosporine, azathioprine, methotrexate, mycophenolate mofetil) □ Topical calcineurin inhibitor
□ **Yes** □ **No**	**Does the patient have a history of <u>contraindication or intolerance</u> to any of the following?** *(If yes, check which applies and complete "Previous Medication Trials/Contraindications" section on first page)* □ Low-potency topical corticosteroid (for treatment of the face, skin folds, or other critical areas) OR medium-potency or higher topical corticosteroid (for treatment of other areas) □ Phototherapy in accordance with current consensus guidelines □ Systemic immunosuppressives in accordance with current consensus guidelines (e.g., cyclosporine, azathioprine, methotrexate, mycophenolate mofetil) □ Topical calcineurin inhibitor
	CONTINUATION OF THERAPY - ASTHMA
□ **Yes** □ **No**	**Is Dupixent prescribed by or in consultation with an appropriate specialist (e.g., allergist, immunologist, pulmonologist)?**
□ **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 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?**
	CONTINUATION OF THERAPY - CHRONIC RHINOSINUSITIS WITH NASAL POLYPOSIS
□ **Yes** □ **No**	**Does the patient have documented evidence of improvement in disease severity?**

Provider Signature: _____ **Date:** _____

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