UnitedHealthcare Community Plan

Dupixent (dupilumab) - Washington
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.

Apple Health Preferred Drug list: https://www.hca.wa.gov/assets/billers-and-providers/apple-health-preferred-drug-list.xlsx

Section A – Member Information

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

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

Medication Name	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

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

1. Indicate patient diagnosis:
   - ☐ Moderate to Severe chronic atopic dermatitis
   - ☐ Asthma with an eosinophilic phenotype
   - ☐ Oral corticosteroid dependent asthma
   - ☐ Chronic rhinosinusitis with bilateral nasal polyposis
   - ☐ Other. Specify: _____

2. Is this prescribed by or in consultation with any of the following (check all that apply):
   - ☐ Allergy/ Immunology
   - ☐ Dermatology
   - ☐ Ear, nose, or throat specialist
   - ☐ Pulmonology
   - ☐ Other. Specify: _____

For diagnosis of Atopic Dermatitis, complete the following:

3. What is patient's current weight? _____ kg Date taken: _____

Continuation of therapy for atopic dermatitis:

4. Is there clinical documentation of disease stability or improvement defined by any of the following (check all that apply)?
   - ☐ At least 20% reduction in body surface area (BSA) involvement
   - ☐ Achieved or maintained clear or minimal disease from baseline (equivalent to Investigator's Global Assessment (IGA) score of 0 or 1)
   - ☐ Experienced or maintained a decrease in Eczema Area and Severity Index (EASI) score of at least 50%

5. Does patient have documentation of improvement in functional impairment for any of the following? (Check all that apply).
   - ☐ Improvement in of limitation of activities of daily living (ADLs)
   - ☐ Skin infections
   - ☐ Sleep disturbances
   - ☐ Other. Specify: _____

New start for atopic dermatitis:

6. Does patient have any of the following (check all that apply)?
   - ☐ At least 10% body surface area (BSA) involvement
   - ☐ A disease severity scale scoring demonstrating severe chronic atopic dermatitis (e.g., Investigator's Global Assessment (IGA) score of 3 or greater; Eczema Area and Severity Index (EASI), Patient Oriented Eczema Measure (POEM); etc.)
   - ☐ None of the above

7. Does patient have documentation of functional impairment for any of the following? (Check all that apply)
   - ☐ Limitation of activities of daily living (ADLs)
   - ☐ Skin infections
   - ☐ Sleep disturbances
   - ☐ Other. Specify: _____

8. Indicate if the patient has a history of failure, intolerance, or contraindication to any of the following (check all that apply):
   - ☐ **For children and adolescents:** Two preferred medium potency topical corticosteroids in the previous 6 months with at least a 28-day trial for each
   - ☐ **For adults:** Two preferred high or very high potency topical corticosteroids in the previous 6 months with at least a 28-day trial for each
   - ☐ Contraindication(s) to all preferred topical corticosteroids.
     - ☐ Treatment of sensitive areas (face, anogenital, skin folds) not responding to low potency desonide or hydrocortisone
     - ☐ History of steroid induced atrophy
     - ☐ Long-term uninterrupted use
   - ☐ One preferred topical calcineurin inhibitors (i.e., pimecrolimus, tacrolimus) for daily treatment for at least 28 days
   - ☐ Contraindication(s) to topical calcineurin inhibitors (i.e., pimecrolimus, tacrolimus)
     - ☐ Patient age less than 2 years of age
   - ☐ Phototherapy
   - ☐ Systemic Immunosuppressants: (i.e., methotrexate, cyclosporine, azathioprine, or mycophenolate)
   - ☐ Systemic corticosteroids
   - ☐ Crisaborole (Eucrisa) daily treatment for at least 28 days

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For diagnosis of Asthma, complete the following:

Continuation of therapy for asthma with an eosinophilic phenotype or asthma with oral corticosteroid dependent asthma:

9. Is there documentation of disease improvement compared to baseline measures (e.g., reduced missed days from work or school, improved FEV_1, ACQ or ACT scores, decrease in burst of systemic corticosteroids, etc.)?
   ☐ Yes ☐ No

10. **For asthma with oral corticosteroid dependent asthma:** Has the patient had a reduction in daily oral corticosteroid dosage or usage? ☐ Yes ☐ No

New start for asthma with an eosinophilic phenotype or asthma with oral corticosteroid dependent asthma:

11. Has patient had any of following (check all that apply):
    ☐ FEV_1 less than (<) 80% predicted
    ☐ Two or more bursts of systemic corticosteroids in last 12 months
    ☐ Poor symptom control (ACQ score consistently greater than 1.5 or ACT score consistently less than 20)
    ☐ **For diagnosis of asthma with an eosinophilic phenotype**: Frequent (at least twice per year) additional medical treatment such as: emergency department (ED) visits, hospitalizations, treatment with mechanical ventilation, or unplanned (sick) office visits
    ☐ **For diagnosis of asthma with an eosinophilic phenotype**: Limitation of activities of daily living, nighttime awakening, or dyspnea

12. Will this be used in combination with other monoclonal antibodies (benralizumab, omalizumab, mepolizumab, reslizumab)? ☐ Yes ☐ No

13. Will patient be using in combination with additional asthma controller medications?
    ☐ Yes, please indicate the medication and duration of use. _____
    ☐ No, please explain. _____

14. **For diagnosis of asthma with oral corticosteroid dependent asthma:** Does the patient have a history of failure (remains symptomatic after 6 weeks) with daily oral corticosteroids, in addition to high-dose inhaled corticosteroids in combination with additional controller(s)? ☐ Yes ☐ No

15. **For diagnosis of asthma with an eosinophilic phenotype:** Does the patient have a history of failure (remains symptomatic after 6 weeks), contraindication or intolerance to high-dose inhaled corticosteroids, in combination with additional controller(s)? ☐ Yes ☐ No

16. **For diagnosis of asthma with an eosinophilic phenotype:**
    What is patient's blood eosinophil count? _____cells/ µL Date taken: _____

17. **For diagnosis of asthma with an eosinophilic phenotype:** Does the patent have a history of failure, contraindication or intolerance to the preferred asthma monoclonal antibodies listed on the AHPDL?
    ☐ Yes ☐ No

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For diagnosis of chronic rhinosinusitis with nasal polyposis, complete the following:

Continuation of therapy for chronic rhinosinusitis with nasal polyposis:

18. Does patient have clinical documentation of disease improvement compared to baseline defined as a reduction in sinusitis-related symptoms, (such as nasal obstruction, nasal discharge, nasal polyp size, facial pain, and pressure, etc.)? ☐ Yes ☐ No

19. Will the patient continue to use intranasal corticosteroids with dupilumab? ☐ Yes ☐ No

New start chronic rhinosinusitis with nasal polyposis:

20. Is there clinical documentation in the patient's file confirming the diagnosis of chronic rhinosinusitis with nasal polyposis? ☐ Yes ☐ No

21. Does patient have a history of persistent symptoms of rhinosinusitis after completion of 2 months of intranasal corticosteroid use? ☐ Yes ☐ No

22. Does patient have a history of failure, intolerance, or contraindication to short courses of systemic oral corticosteroids? ☐ Yes ☐ No

23. Will the patient continue to use intranasal corticosteroids with dupilumab? ☐ Yes ☐ No

CHART NOTES ARE REQUIRED WITH THIS REQUEST

Prescriber signature	Prescriber specialty	Date