Health Partners Plans

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 or in consultation with a pulmonologist, allergist, immunologist, or dermatologist, or otolaryngologist?

☐ Yes ☐ No

Q2. 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

Q3. Is Dupixent being used for add on maintenance therapy for the treatment of moderate to severe asthma with eosinophilic type?

☐ Yes ☐ No

Q4. Is Dupixent being used for add-on maintenance therapy treatment in patients with inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP)?

☐ Yes ☐ No

Q5. Is the patient 12 years of age or older?

☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q7. For patients with moderate-to-severe atopic dermatitis whose disease is not adequately controlled with topical

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prescription therapies or when those therapies are not advisable, is there documentation showing that the patient had a trial of or intolerance to topical corticosteroids and topical tacrolimus ointment?

☐ Yes ☐ No

Q8. For add on maintenance therapy for the treatment of moderate to severe asthma with eosinophilic type, is there documentation showing that the patient has a diagnosis of eosinophilic asthma?

☐ Yes ☐ No

Q9. Is there documentation showing that the patient had a trial of or intolerance to combination therapies (inhaled steroids, long acting beta-agonists, antileukotrienes, theophylline)?

☐ Yes ☐ No

Q10. 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

Q11. Is there documentation showing that the patient had a trial of or intolerance to combination therapies (inhaled steroids, long acting beta-agonists, antileukotrienes, theophylline)?

☐ Yes ☐ No

Q12. 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

Q13. 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

Q14. Additional Information:

Q15. Requested Duration:

☐ 12 months

Prescriber Signature

Date

2020 Medicare Prior Authorization Request

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