Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

Dupixent - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

Jefferson Health 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.

Member Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare Advantage	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. Is this a reauthorization request? If YES, go to 2. If NO, go to 3.

☐ Yes ☐ No

Q2. For REAUTHORIZATION: Has the prescriber provided confirmation of a positive clinical response?

☐ Yes ☐ No

Q3. Will Dupixent be prescribed by a pulmonologist, allergist, immunologist, dermatologist, otolaryngologist, or gastroenterologist?

☐ Yes ☐ No

Q4. Is the patient 6 months of age or older for atopic dermatitis, 6 years of age or older for eosinophilic phenotype or oral corticosteroid dependent asthma,12 years of age or older for CRSwNP, 18 years of age or older for prurigo nodularis or COPD, OR 1 year of age or older for EOE?

☐ Yes ☐ No

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Q5. 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? If YES, go to Q12.

☐ Yes ☐ No

Q6. Is Dupixent being used for add on maintenance therapy for the treatment of moderate to severe asthma with eosinophilic type?

☐ Yes ☐ No

Q7. Is Dupixent being used for add on maintenance therapy for the treatment of oral corticosteroid dependent asthma? If YES, go to Q13.

☐ Yes ☐ No

Q8. Is Dupixent being used for add-on maintenance therapy treatment in patients with inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP)? If YES, go to Q15.

☐ Yes ☐ No

Q9. Is Dupixent being used for the treatment of eosinophilic esophagitis (EoE)? Please add If YES, go to Q17.

☐ Yes ☐ No

Q10. Is Dupixent being used for the treatment of Prurigo nodularis? If YES, go to Q20.

☐ Yes ☐ No

Q11. Is Dupixent being used as add-on maintenance treatment of adult patients with inadequately controlled chronic obstructive pulmonary disease (COPD) and an eosinophilic phenotype? If YES, go to Q23.

☐ Yes ☐ No

Q12. For patients with moderate-to-severe atopic dermatitis whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable, is there documentation showing that the patient had a trial of, intolerance to, or contraindication to at

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least one topical corticosteroid and at least one topical calcineurin inhibitor for patients 2 years of age and older OR at least one topical steroid for patients under the age of 2? If YES, go to Q25.

☐ Yes ☐ No

Q13. For add on maintenance therapy for the treatment of moderate to severe asthma with eosinophilic type, is there diagnosis of eosinophilic asthma including eosinophil count equal to or greater than 150 microliters? Labs must be attached

☐ Yes ☐ No

Q14. Is there documentation showing that the patient had a trial of, intolerance to, or contraindication to at least one combination therapy (inhaled steroids, long acting beta-agonists, antileukotrienes, theophylline)?

☐ Yes ☐ No

Q15. 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

Q16. Is there documentation showing that the patient had a trial of, intolerance to, or contraindication to at least one combination therapy (inhaled steroids, long acting beta-agonists, antileukotrienes, theophylline)?

☐ Yes ☐ No

Q17. For add-on maintenance treatment in patients with inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP) is there documentation of a diagnosis of chronic rhinosinusitis with nasal polyposis?

☐ Yes ☐ No

Q18. Is there documentation showing that the patient had a trial of, intolerance to, or contraindication to at least one intranasal corticosteroid?

☐ Yes ☐ No

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Q19. Is there documentation showing that the patient had a trial of, intolerance to, or contraindication to at least one systemic corticosteroid therapy?

☐ Yes ☐ No

Q20. Is there documentation of a diagnosis of eosinophilic esophagitis?

☐ Yes ☐ No

Q21. Is there documentation showing that the patient had a trial of, intolerance to, or contraindication to at least one proton pump inhibitor?

☐ Yes ☐ No

Q22. Is there documentation showing that the patient had a trial of, intolerance to, or contraindication to inhaled fluticasone propionate?

☐ Yes ☐ No

Q23. Is there documentation of a diagnosis of Prurigo nodularis?

☐ Yes ☐ No

Q24. Is there documentation showing that the patient had a trial of, intolerance to, or contraindication to at least one high potency topical steroid?

☐ Yes ☐ No

Q25. Is there documentation showing a diagnosis of COPD with an eosinophilic phenotype including eosinophil count greater than >300 cells/microL (lab results required)?

☐ Yes ☐ No

Q26. Is there documentation showing the patient's COPD is inadequately controlled?

☐ Yes ☐ No

Q27. Is there documentation showing a trial of, intolerance to, or contraindication to at least one inhaled combination therapy (including LAMA/LABA or LAMA/LABA/ICS combination therapies)?

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☐ Yes ☐ No

Q28. Is there documentation showing a trial of, intolerance to, or contraindication to chronic azithromycin therapy or roflumilast?

☐ Yes ☐ No

Q29. Requested Duration:

☐ 12 Months ☐ Other:

Q30. Additional Information:

_____ _____

Prescriber Signature Date

v2025