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

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

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Dupixent

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)* □ Atopic dermatitis □ Chronic rhinosinusitis with nasal polyposis (CRSwNP) □ Moderate-to-severe asthma
□ **Yes** □ **No**	**Is Dupixent prescribed by one of the following?** *(If yes, check which applies)* □ Allergist □ Dermatologist □ Immunologist □ Otolaryngologist □ Pulmonologist
	ATOPIC DERMATITIS
□ **Yes** □ **No**	**Does any of the following apply to the patient?** *(If yes, check which applies)* □ Moderate to severe chronic atopic dermatitis □ Chronic atopic dermatitis that has been determined to be severe based on physician assessment
□ **Yes** □ **No**	**Does the patient have a history of failure, contraindication, or intolerance to any of the following topical therapies?** *(If yes, check which applies and complete Section D above)* □ Medium to very-high potency topical corticosteroid [e.g., Elocon (mometasone furoate), Synalar (fluocinolone acetonide), Lidex (fluocinonide)] □ Topical calcineurin inhibitor [e.g., Elidel (pimecrolimus), Protopic (tacrolimus)] □ Eucrisa (crisaborole)
□ **Yes** □ **No**	**Is the patient receiving Dupixent in combination with another biologic medication [e.g., Xolair (omalizumab), Rituxan (rituximab), Enbrel (etanercept), Remicade/Inflectra (infliximab)]?**
	CHRONIC RHINOSINUSITIS WITH NASAL POLYPOSIS (CRSWNP)
□ **Yes** □ **No**	**Has the patient had any of the following symptoms for greater than or equal to 12 weeks duration?** *(If yes, check which applies)* □ Mucopurulent discharge □ Nasal obstruction and congestion □ Decreased or absent sense of smell □ Facial pressure or pain
□ **Yes** □ **No**	**Does the patient have any of the following?** *(If yes, check which applies)* □ Evidence of inflammation on paranasal sinus examination or computed tomography (CT) □ Evidence of purulence coming from paranasal sinuses or ostiomeatal complex
□ **Yes** □ **No**	**Does the patient have nasal polyps?**
□ **Yes** □ **No**	**Has the patient required any of the following?** *(If yes, check which applies)* □ Prior sinonasal surgery □ Systemic corticosteroids in the previous 2 years
□ **Yes** □ **No**	**Has the patient been unable to obtain symptom relief after a trial of any of the following agents/classes?** *(If yes, check which applies and complete Section D above)* □ Nasal saline irrigations □ Intranasal corticosteroids (e.g. fluticasone, mometasone, triamcinolone, etc.) □ Antileukotriene agents (e.g. montelukast, zafirlukast, zileuton)
□ **Yes** □ **No**	**Is the patient receiving Dupixent in combination with another biologic medication [e.g., Xolair (omalizumab), Nucala (mepolizumab), Cinqair (resilizumab), Fasenra (benralizumab)]?**
□ **Yes** □ **No**	**Will the patient receive Dupixent as add-on maintenance therapy in combination with intranasal corticosteroids?**

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Dupixent

PRIOR AUTHORIZATION REQUEST FORM

Member First name:	Member Last name:	Member DOB:

MODERATE TO SEVERE ASTHMA	
□ **Yes** □ **No**	**Is the patient's asthma classified as uncontrolled or inadequately controlled as defined by any of the following?** *(If yes, check which applies)* □ Poor symptom control (e.g., Asthma Control Questionnaire [ACQ] score consistently greater than 1.5 or Asthma Control Test [ACT] score consistently less than 20) □ Two or more bursts of systemic corticosteroids for at least 3 days each in the previous 12 months □ Asthma-related emergency treatment (e.g., emergency room visit, hospital admission, or unscheduled physician's office visit for nebulizer or other urgent treatment) □ Airflow limitation (e.g., after appropriate bronchodilator withhold forced expiratory volume in 1 second [FEV1] less than 80% predicted [in the face of reduced FEV1/forced vital capacity [FVC] defined as less than the lower limit of normal])
□ **Yes** □ **No**	**Is the patient currently dependent on oral corticosteroids for the treatment of asthma?**
□ **Yes** □ **No**	**Will Dupixent be used in combination with one high dose (appropriately adjusted for age) combination inhaled corticosteroid (ICS)/long-acting beta2 agonist (LABA) [e.g., Advair/AirDuo Respiclick (fluticasone propionate/salmeterol), Symbicort (budesonide/formoterol), Breo Ellipta (fluticasone furoate/vilanterol)]?** *If yes, list ICS/LABA product:*
□ **Yes** □ **No**	**Will the patient use Dupixent in combination with any of the following?** □ One high-dose (appropriately adjusted for age) inhaled corticosteroid (ICS) product [e.g., ciclesonide (Alvesco), mometasone furoate (Asmanex), beclomethasone dipropionate (QVAR)] □ One additional asthma controller medication [e.g., LABA - olodaterol (Striverdi) or indacaterol (Arcapta); leukotriene receptor antagonist – montelukast (Singulair); theophylline] *If yes, list combination therapy:*
□ **Yes** □ **No**	**Will medical records (e.g., chart notes, laboratory values, etc.) be submitted documenting that asthma is an eosinophilic phenotype as defined by a baseline (pre-dupilumab treatment) peripheral blood eosinophil level greater than or equal to 150 cells/microliter within the past 6 weeks?** *(DOCUMENTATION REQUIRED)*
□ **Yes** □ **No**	**Will the patient receive Dupixent in combination with any of the following?** *(If yes, check which applies)* □ Anti-interleukin-5 therapy [e.g. Nucala (mepolizumab), Cinqair (resilizumab), Fasenra (benralizumab)] □ Anti-IgE therapy [e.g. Xolair (omalizumab)]
CONTINUATION OF THERAPY - ATOPIC DERMATITIS	
□ **Yes** □ **No**	**Is there documentation of positive clinical response to Dupixent therapy?**
CONTINUATION OF THERAPY - CHRONIC RHINOSINUSITIS WITH NASAL POLYPOSIS (CRSWNP)	
□ **Yes** □ **No**	**Is there documentation of positive clinical response to Dupixent therapy?**
□ **Yes** □ **No**	**Will the patient continue to receive Dupixent as add-on maintenance therapy in combination with intranasal corticosteroids?**
CONTINUATION OF THERAPY - MODERATE TO SEVERE ASTHMA	
□ **Yes** □ **No**	**Is there documentation of positive clinical response to Dupixent therapy as demonstrated by any of the following?** *(If yes, check which applies)* □ Reduction in the frequency of exacerbations □ Decreased utilization of rescue medications □ Increase in percent predicted forced expiratory volume in 1 second (FEV1) from pretreatment baseline □ Reduction in severity or frequency of asthma-related symptoms (e.g., wheezing, shortness of breath, coughing, etc.) □ Reduction in oral corticosteroid requirements
□ **Yes** □ **No**	**Is Dupixent being used in combination with an inhaled corticosteroid (ICS)-containing controller medication?**

Physician Signature: _____ **Date:** _____