aetna™

Aetna Better Health®

**Fax completed prior authorization request form to** 844-802-1412 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at https://www.aetnabetterhealth.com/Illinois-medicaid

# Dupixent

# Pharmacy Prior Authorization Request Form

**Do not copy for future use. Forms are updated frequently.**

**REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification to support diagnosis**

| **Member Information** | | | |
|---|---|---|---|
| Member Name (first & last): | Date of Birth: | Gender: ☐ Male ☐ Female | Height: |
| Member ID: | City: | State: | Weight: |

| **Prescribing Provider Information** | | | |
|---|---|---|---|
| Provider Name (first & last): | Specialty: | NPI# | DEA# |
| Office Address: | City: | State: | Zip Code: |
| Office Contact: | Office Phone | Office Fax: | |

| **Dispensing Pharmacy Information** | | |
|---|---|---|
| Pharmacy Name: | Pharmacy Phone: | Pharmacy Fax: |

| **Requested Medication Information** | | | | |
|---|---|---|---|---|
| Medication request is NOT for an FDA approved, or compendia-supported diagnosis (circle one): ☐ Yes ☐ No | Diagnosis: | ICD-10 Code: | | |
| Are there any contraindications to formulary medications? If yes, please specify: | ☐ Yes ☐ No | ☐ New request | ☐ Continuation of therapy request | |
| Directions for Use: | Strength: | Dosage Form: | | |
| | Quantity: / Day Supply: | Duration of Therapy/Use: | | |
| What medication(s) has the member tried and failed for this diagnosis? Please specify below. | | | | |

| **Turn-Around Time for Review** | |
|---|---|
| ☐ Standard – (24 hours) | ☐ **Urgent** – waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision.<br>Signature: _____ |

| **Clinical Information** | | | | | |
|---|---|---|---|---|---|
| ☐ **Moderate to Severe Atopic Dermatitis** | | | | | |
| Were lab results using Patient-Oriented Eczema Measure (POEM) score at ≥ 8? | ☐ Yes | ☐ No | Were lab results of Investigator's Global Assessment (IGA) score at ≥ 3? | ☐ Yes | ☐ No |
| Was there inadequate response OR intolerable side effect with TWO preferred - medium to very high potency - topical corticosteroids? | ☐ Yes | ☐ No | Was there inadequate response OR intolerable side effect with ONE preferred low potency topical corticosteroid, for sensitive areas, such as face? | ☐ Yes | ☐ No |
| Was there inadequate response OR intolerable side effect to tacrolimus? | ☐ Yes | ☐ No | Was there inadequate response or intolerable side effect to ONE oral systemic therapy such as methotrexate OR cyclosporine OR azathioprine OR mycophenolate? | ☐ Yes | ☐ No |
| ☐ **Renewal ONLY** | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Did member have a response to therapy, for example, reduction in lesions? | ☐ Yes | ☐ No | Was the score for Patient-Oriented Eczema Measure (POEM) 0 to 2 (clear or almost clear)? | ☐ Yes | ☐ No |
| Was the Investigator's Global Assessment (IGA) score 0 or 1 (clear or almost clear)? | | | | ☐ Yes | ☐ No |
| ☐ **Moderate to Severe Asthma** | | | | | |
| Was the eosinophilic phenotype, with pretreatment eosinophil count ≥150/microL? | ☐ Yes | ☐ No | Does member have corticosteroid dependent asthma (≥5 mg of oral prednisone or equivalent per day)? | ☐ Yes | ☐ No |
| Will Dupixent be used as ADD ON therapy to a medium or high dose ICS plus ONE additional controller such as LABA OR LAMA? | ☐ Yes | ☐ No | Was there compliance with the medium to high dose ICS plus ONE LABA OR LAMA OR another controller for at least THREE months AND member remained symptomatic? | ☐ Yes | ☐ No |
| Is there daily use of rescue medications such as SABA? | ☐ Yes | ☐ No | Are nighttime symptoms occurring one OR more times per week? | ☐ Yes | ☐ No |
| Were there a minimum of TWO exacerbations in the last 12 months requiring additional medical treatment (For example, systemic corticosteroids, ER visits, or hospitalization)? | ☐ Yes | ☐ No | Is the FEV1< 80% predicted? | ☐ Yes | ☐ No |
| Will Dupixent be used with another monoclonal antibody? | | | | ☐ Yes | ☐ No |
| ☐ **Renewal ONLY** | | | | | |
| Was there a response to therapy such as decrease in exacerbations OR decrease in dose of oral steroids OR improvement in FEV1 from baseline)? | | | | ☐ Yes | ☐ No |
| Will Dupixent continued to be used as add on therapy to another asthma medication? | ☐ Yes | ☐ No | Will Dupixent be used with another monoclonal antibody? | ☐ Yes | ☐ No |
| ☐ **Chronic Rhinosinusitis with Nasal Polyposis** | | | | | |
| Will Dupixent be used as add-on therapy to intranasal corticosteroids? | | | | ☐ Yes | ☐ No |
| Have symptoms persisted for at least 12 weeks and TWO out of FOUR hallmark signs AND symptoms are present? (if yes, check that apply):<br>Yes ☐ No ☐ | | | ☐ Mucopurulent drainage<br>☐ Nasal obstruction<br>☐ Decreased sense of smell<br>☐ Facial pain, pressure, and/or fullness | | |
| Has prescriber confirmed mucosal inflammation is present? | ☐ Yes | ☐ No | Was condition inadequately controlled by systemic corticosteroids AND/OR sinus surgery following intranasal corticosteroids? | ☐ Yes | ☐ No |
| ☐ **Renewal ONLY** | | | | | |
| Was there response to therapy? | ☐ Yes | ☐ No | Was there decrease in bilateral endoscopic nasal polyps score from baseline? | ☐ Yes | ☐ No |
| Was there a decrease in the nasal congestion / obstruction score from baseline? | ☐ Yes | ☐ No | Will Dupixent continue to be used as add on therapy to intranasal corticosteroids? | ☐ Yes | ☐ No |
| **Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records.** | | | | | |
| | | | | | |

**Signature affirms that information given on this form is true and accurate and reflects office notes.**

**Prescribing Provider's Signature:** _____ **Date:** _____

**Please note: Incomplete forms or forms without the chart notes will be returned**

Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Standard turnaround time is 24 hours. You can call 866-329-4701 to check the status of a request.