AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM

Dupixent®

Fax back to: 1-855-799-2553

If the following information is not coplete, correct, or legible, the PA process can be delayed.

Please use one form per member.

MEMBER INFORMATION

Last Name: _____

First Name: _____

Medicaid ID Number: _____

Date of Birth: _____

Expected Pregnancy Term Date: _____

Requested Start Date: _____

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name: _____

First Name: _____

NPI Number: _____

Phone Number: _____

Fax Number: _____

DIAGNOSIS AND MEDICAL INFORMATION

For a diagnosis of chronic rhinosinusitis with nasal polyps only:

1. Is the member 12 years of age or older?
   ☐ Yes ☐ No
2. Does the member have inadequate response after 3 consistent months' use of preferred intranasal steroids or oral corticosteroids?
   ☐ Yes ☐ No
3. Is the member concurrently being treated with intranasal corticosteroids?
   ☐ Yes ☐ No
4. Has the physician assessed baseline disease severity utilizing an objective measurement/tool?
   ☐ Yes ☐ No

(Form continued on next page)

Member's Last Name: **Member's First Name:**

For a diagnosis of moderate to severe asthma:

1. Is the member 6 years of age or older?
   ☐ Yes ☐ No
2. Does the member have a diagnosis of moderate to severe asthma with either:
   - Asthma with eosinophilic phenotype with eosinophil count ≥ 150 cells/mcL; **OR**
   - Oral corticosteroid-dependent asthma with at least 1 month of daily oral corticosteroid use within the last 3 months

   ☐ Yes ☐ No

For a diagnosis of eosinophilic esophagitis (EoE):

1. Is the member 1 year of age or older?
   ☐ Yes ☐ No
2. Does the member weigh ≥ 15 kg?
   ☐ Yes ☐ No
3. Is Dupixent prescribed by or in consultation with an allergist or gastroenterologist?
   ☐ Yes ☐ No
4. Has the member responded clinically to treatment with a topical glucocorticosteroid or proton pump inhibitor?
   ☐ Yes ☐ No

For adult members with inadequately controlled chronic obstructive pulmonary disease (COPD) and an eosinophilic phenotype:

1. Is the member 18 years of age or older?
   ☐ Yes ☐ No
2. Is Dupixent prescribed by or in consulation with a pulmonologist?
   ☐ Yes ☐ No
3. Does the member have a diagnosis of COPD that is inadequately controlled and a minimum blood eosinophil count of 300 cells/mcL at screening, measured within the past 12 months?
   ☐ Yes ☐ No
4. Is the member receiving maximal inhaled therapy consisting of a long-acting muscarinic antagonist (LAMA), long-acting beta agonist (LABA), and inhaled corticosteroid (ICS) (or therapy of LAMA plus LABA if ICS is contraindicated)?
   ☐ Yes ☐ No
5. Does the member have a history of at least 2 moderate (requiring treatment with systemic corticosteroids and/or antibiotics) or 1 severe exacerbation(s) (resulting in hospitalization or observation for over 24 hours in an emergency department or urgent care facility) in the previous year, with 1 exacerbation occurring while the patient was on maximal inhaled therapy?
   ☐ Yes ☐ No

Member's Last Name: **Member's First Name:**

For adult members with a diagnosis of prurigo nodularis (PN):

1. Is the member 18 years of age or older?
   ☐ Yes ☐ No
2. Does the member have a diagnosis of PN?
   ☐ Yes ☐ No
3. Is Dupixent prescribed by or in consultation with a dermatologist, allergist, or immunologist?
   ☐ Yes ☐ No

For renewal:

1. Has the member experienced a therapeutic benefit from the requested medication?
   ☐ Yes ☐ No
2. Is the member free of toxicity from the requested medication?
   ☐ Yes ☐ No

Prescriber Signature (Required) **Date**

By signature, the Physician confirms the above information is accurate and verifiable by patient records.

Please include ALL requested information; Incomplete forms will delay the PA process.