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 for a list of preferred alternatives

UnitedHealthcare Community Plan

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)* □ Moderate chronic atopic dermatitis □ Severe chronic atopic dermatitis □ Moderate to severe Asthma
□ **Yes** □ **No**	**Is the patient receiving 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)] □ Biologic medication [e.g. Enbrel (etanercept), Rituxan (rituximab), Remicade/Inflectra (infliximab)] *If yes, list rationale:*
□ **Yes** □ **No**	**Is Dupixent prescribed by one of the following?** *(If yes, check which applies)* □ Dermatologist □ Allergist □ Immunologist □ Pulmonologist
CHRONIC ATOPIC DERMATITIS	
□ **Yes** □ **No**	**Did the patient require systemic immunosuppressive therapy for control with any of the following?** *(If yes, check which applies and complete Section D above)* □ Cyclosporine □ Azathioprine □ Methotrexate □ Mycophenolate mofetil
□ **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)
MODERATE TO SEVERE ASTHMA ***(continued on next page)***	
□ **Yes** □ **No**	**Is the patient's asthma uncontrolled or inadequately controlled as defined by at least one 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) *List rationale:* □ Two or more bursts of systemic corticosteroids for at least 3 days each in the previous 12 months *List corticosteroid and dates:* □ Asthma-related emergency treatment (e.g., emergency room visit, hospital admission, or unscheduled physician's office visit for nebulizer or other urgent treatment) *List emergency 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]) *List rationale:* □ Patient is currently dependent on oral corticosteroids for the treatment of asthma *List oral corticosteroid:*
□ **Yes** □ **No**	**Is there submission of medical records (e.g., chart notes, laboratory values, etc.) documenting that asthma is an eosinophilic phenotype as defined by a baseline (pre-dupilumab treatment) peripheral blood eosinophil level ≥ 150 cells/µL within the past 6 weeks?** *If yes, list peripheral blood eosinophil level and date:*

UnitedHealthcare Community Plan

Dupixent

PRIOR AUTHORIZATION REQUEST FORM

Member First name:	Member Last name:	Member DOB:

□ **Yes** □ **No**	**Is the patient currently dependent on oral corticosteroids for the treatment of asthma?** *If yes, list corticosteroids:*
□ **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)?** *If yes, list combo ICS/LABA product:*
□ **Yes** □ **No**	**Will Dupixent be used in combination with one high-dose (appropriately adjusted for age) ICS product?** *If yes, list high dose ICS product:*
□ **Yes** □ **No**	**Will Dupixent be used in combination with any additional asthma controller medications? (e.g., long-acting beta2 agonist, theophylline, leukotriene receptor antagonist)** *If yes, list additional product:*
CONTINUATION OF THERAPY	
□ **Yes** □ **No**	**Does the patient have a documented positive clinical response to Dupixent 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 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 *If other, list response:*

Physician Signature: _____ **Date:** _____