UnitedHealthcare Community Plan

Dupixent (dupilumab) - Washington
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 may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Apple Health Preferred Drug list: https://www.hca.wa.gov/assets/billers-and-providers/apple-health-preferred-drug-list.xlsx

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

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

Medication Name	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

Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

1. Indicate patient diagnosis:
   ☐ Moderate to Severe chronic atopic dermatitis
   ☐ Asthma with an eosinophilic phenotype
   ☐ Oral corticosteroid dependent asthma
   ☐ Chronic rhinosinusitis with bilateral nasal polyposis
   ☐ Other. Specify: ________________________

2. Will this be used in combination with any of the following (check all that apply):
   ☐Anti-interleukin 5 therapy (e.g., mepolizumab, reslizumab, benralizumab)
   ☐Anti-interleukin 13 therapy (e.g., tralokinumab-ldrm
   ☐Janus kinase inhibitors (e.g., upadacitinib, abrocitinib)

3. Is this prescribed by or in consultation with any of the following (check all that apply):
   ☐ Allergy/ Immunology ☐ Dermatology ☐ Ear, nose, or throat specialist
   ☐ Pulmonology ☐ Other. Specify: ______________________

4. What is patient's current weight? _________ kg Date taken: _______________

For diagnosis of Atopic Dermatitis, complete the following:

Continuation of therapy for atopic dermatitis:

5. Does patient have clinical documentation of disease stability or improvement defined by any of the following? (Check all that apply)
   ☐ At least 20% reduction in body surface area (BSA) involvement
   ☐ Achieved/maintained clear or minimal disease from baseline (equivalent to Investigator's Global Assessment (IGA) score of 0 or 1)
   ☐ Experienced or maintained a decrease in Eczema Area and Severity Index (EASI) score of at least 50%

6. Does patient have documentation of improvement in functional impairment for any of the following? (Check all that apply).
   ☐ Improvement in of limitation of activities of daily living (ADLs) ☐ Skin infections
   ☐ Sleep disturbances ☐ Other. Specify: _________________

New start for atopic dermatitis:

7. Does patient have any of the following (check all that apply)?
   ☐ At least 10% body surface area (BSA) involvement
   ☐ A disease severity scale scoring demonstrating severe chronic atopic dermatitis (e.g., Investigator's Global Assessment (IGA) score of 3 or greater; Eczema Area and Severity Index (EASI), Patient Oriented Eczema Measure (POEM); etc.)
   ☐ None of the above

8. Does patient have documentation of functional impairment for any of the following? (Check all that apply)
   ☐ Limitation of activities of daily living (ADLs) ☐ Skin infections
   ☐ Sleep disturbances ☐ Other. Specify: _________________

9. Indicate if the patient has a history of failure, intolerance, or contraindication to any of the following for a daily treatment minimum of 28 days each (check all that apply):
   ☐ Topical corticosteroids of at least medium/moderate potency
   ☐ Topical calcineurin inhibitors (pimecrolimus or tacrolimus)
   ☐ PDE-4 inhibitors (crisaborole)

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Member First name:	Member Last name:	Member DOB:

For diagnosis of Asthma, complete the following:

Continuation of therapy for asthma with an eosinophilic phenotype or asthma with oral corticosteroid dependent asthma:

10. Is there documentation of disease improvement compared to baseline measures (e.g., reduced missed days from work or school, improved FEV_1, ACQ or ACT scores, decrease in burst of systemic corticosteroids, etc.)?
☐ Yes ☐ No

11. **For asthma with oral corticosteroid dependent asthma:** Has the patient had a reduction in daily oral corticosteroid dosage or usage? ☐ Yes ☐ No

New start for asthma with an eosinophilic phenotype or asthma with oral corticosteroid dependent asthma:

12. Has patient had any of following (check all that apply):
☐ FEV_1 less than (<) 80% predicted
☐ One or more bursts of systemic corticosteroids or oral corticosteroid dependency in the previous 12 months
☐ Frequent (at least twice per year) additional medical treatment such as: emergency department (ED) visits, hospitalizations, treatment with mechanical ventilation, or unplanned (sick) office visits
☐ Limitation of activities of daily living, nighttime awakening, or dyspnea

13. Will patient be using in combination with additional asthma controller medications?
☐ Yes, please indicate the medication and duration of use. ______________________________
☐ No, please explain. ______________________________

14. Does the patient have a history of failure (remains symptomatic after 6 weeks), contraindication or intolerance to any of the following (check all that apply)
☐ High-dose inhaled corticosteroids, in combination with additional controller(s)
☐ Daily oral corticosteroids in combination with high-dose inhaled corticosteroids and additional controller(s)

15. **For diagnosis of asthma with an eosinophilic phenotype:**
What is patient's blood eosinophil count? ______cells/ µL Date taken: __________

For diagnosis of chronic rhinosinusitis with nasal polyposis, complete the following:

16. Will the patient continue to use intranasal corticosteroids with dupilumab? ☐ Yes ☐ No

Continuation of therapy for chronic rhinosinusitis with nasal polyposis:

17. Does patient have clinical documentation of disease improvement compared to baseline defined as a reduction in sinusitis-related symptoms, (such as nasal obstruction, nasal discharge, nasal polyp size, facial pain, and pressure, etc.)? ☐ Yes ☐ No

New start chronic rhinosinusitis with nasal polyposis:

18. Is there clinical documentation in the patient's file confirming the diagnosis of chronic rhinosinusitis with nasal polyposis? ☐ Yes ☐ No

19. Does patient have a history of persistent symptoms of rhinosinusitis after completion of 2 months of intranasal corticosteroid use? ☐ Yes ☐ No

20. Does patient have a history of failure, intolerance, or contraindication to short courses of systemic oral corticosteroids? ☐ Yes ☐ No

CHART NOTES ARE REQUIRED WITH THIS REQUEST

Prescriber signature	Prescriber specialty	Date

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