PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Dupixent (dupilumab)

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. What is the prescriber's specialty?

- ☐ Allergy
- ☐ Dermatology
- ☐ Immunology
- ☐ Other (please specify)

Q2. Please provide ICD code(s) for diagnosis.

Q3. Is the patient a new start to Dupixent?

- ☐ Yes
- ☐ No - patient has been stable on Dupixent for less than 16 weeks
- ☐ No - patient has been stable on Dupixent for 16 weeks or more

Q4. Is the patient 18 years or older?

☐ Yes ☐ No

Q5. Does the patient have moderate to severe atopic dermatitis affecting greater than or equal to 10% of body surface area (BSA)?

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☐ Yes ☐ No

Q6. Does the patient have failure of or contraindication to any of the following topical therapies? Please select all that apply

- ☐ One topical calcineurin inhibitor (ex. tacrolimus or Elidel)
- ☐ One medium to super high potency topical corticosteroid
- ☐ Eucrisa
- ☐ Other (Please Specify)

Q7. Does the patient have failure of or contraindication to phototherapy ?

☐ Yes ☐ No

Q8. Does the patient have failure of or contraindication to azathioprine, cyclosporine, methotrexate, OR mycophenolate mofetil?

☐ Yes ☐ No

Q9. For continuation of Dupixent, does the patient have a documented positive clinical response to therapy (e.g. reduction in body surface area involvement, reduction in pruritis severity, etc.)?

☐ Yes ☐ No

Q10. Additional Comments

Q11. How will drug be billed?

- ☐ Pharmacy claim (drug to be billed as a PHARMACY benefit claim and dispensed by pharmacy directly to member)
- ☐ Pharmacy claim (drug to be billed as a PHARMACY benefit claim, but shipped direct to provider to be administered to this specific member)
- ☐ MEDICAL claim (drug to be billed by PROVIDER as a MEDICAL benefit claim as an expense to the provider, and provider to supply drug to member)

Q12. If billing as a MEDICAL claim, what provider will be linked to the claim (i.e. who is the billing entity seeking reimbursement)? Provide Name and NPI

- ☐ Individual prescriber
- ☐ Provider or specialty group
- ☐ Facility

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Prescriber Signature

Date

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.