PriorityHealth

Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Medicare Part B** ☒ **Medicare Part D**

This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

Dupixent™ (dupilumab)

Member

Last Name: ______________________ First Name: ______________________

ID #: ______________________ DOB: ______________ Gender: ______________

Primary Care Physician: ______________________

Requesting Provider: ______________________ Prov. Phone: ______________ Prov. Fax: ______________

Provider Address: ______________________

Provider NPI: ______________________ Contact Name: ______________________

Provider Signature: ______________________ Date: ______________

Drug information

☐ New request ☐ Continuation request

☐ Dupixent 300 mg syringe

☐ Dupixent 200 mg syringe

Start date (or date of next dose): ______________

Date of last dose (if applicable): ______________

Dosing frequency: ______________

Prior authorization criteria

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

For this drug to be covered, the patient must meet the following criteria:

1. Must be used for a medically-accepted indication*
2. Must be 12 years of age or older
3. For moderate to severe atopic dermatitis, must have had a trial and inadequate response to the following:
   a. One medium or higher potency topical steroid (e.g. clobetasol, betamethasone dipropionate, halobetasol, fluocinonide); AND
   b. One topical calcineurin inhibitor (e.g. Elidel or tacrolimus)
4. For moderate to severe asthma, must meet all of the following:
   a. Must have an eosinophilic phenotype or be dependent on oral corticosteroids
   b. Must be used as an add-on to current maintenance treatment with an ICS/LABA inhaler or, if contraindicated or not tolerated, another maintenance medication for the condition
5. Must not be used in combination with other monoclonal antibodies (e.g., Xolair, Nucala)

For continuation, patient must have met the following requirements:

1. Must meet all initial requirements
2. Must have documented clinical benefit from therapy (e.g., decrease in exacerbation frequency, improvement in asthma symptoms, or decrease in oral corticosteroid use)

All fields must be complete and legible for review. Your office will receive a response via fax.

Updated 12/2018
Last reviewed 04/2019

Medically-accepted indication*

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- — *or* — supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System)

Additional information

Note: When criteria are met, duration of approval is 1 year. Dupixent is limited to 4 syringes the first month and 2 syringes per month thereafter

New Request
Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ Moderate to severe atopic dermatitis

1. Has the patient had an inadequate response to 1 medium or higher potency topical steroid?

☐ Yes
☐ No. **Are you requesting an exception to the criteria?**
☐ Yes. ***Rationale for exception***: ______
☐ No

2. Has the patient had an inadequate response to 1 topical calcineurin inhibitor?

☐ Yes
☐ No. **Are you requesting an exception to the criteria?**
☐ Yes. ***Rationale for exception***: ______
☐ No

☐ Moderate to severe asthma

1. Which of the following applies to the patient's asthma?

☐ Eosinophilic phenotype.
Baseline blood eosinophil count (cells/mcL):______ Date:______
☐ Dependent on oral corticosteroids
☐ Neither. **Are you requesting an exception to the criteria?**
☐ Yes. ***Rationale for exception***: ______
☐ No

2. Is Dupixent an add-on to current ICS/LABA inhaler therapy or, if contraindicated or not tolerated, another maintenance medication?

☐ Yes
☐ No. **Are you requesting an exception to the criteria?**
☐ Yes. ***Rationale for exception***: ______
☐ No

☐ *Other – the patient's condition is:* ______
Rationale for Other use: ______

B. **Will Dupixent be used in combination with other monoclonal antibodies (e.g., Xolair, Nucala)?**
- ☐ No
- ☐ Yes. **Are you requesting an exception to the criteria?**
  - ☐ Yes. ***Rationale for exception***: ____________________
  - ☐ No

C. **Please document which medication(s) the patient has used or is using:**

Drug	Dose	Dates of Use

Continuation
Priority Health Precertification Documentation

A. **Is this add-on to current ICS/LABA inhaler therapy or, if contraindicated or not tolerated, another maintenance medication?**
- ☐ Yes
- ☐ No. **Are you requesting an exception to the criteria?**
  - ☐ Yes. ***Rationale for exception***: ____________________
  - ☐ No

B. **Will Dupixent be used in combination with other monoclonal antibodies (e.g., Xolair, Nucala)?**
- ☐ No
- ☐ Yes. **Are you requesting an exception to the criteria?**
  - ☐ Yes. ***Rationale for exception***: ____________________
  - ☐ No

C. **Has documentation of clinical benefit from use of Dupixent been provided?**
- ☐ Yes. Check all that apply:
  - ☐ Decrease in exacerbation frequency
  - ☐ Improvement in asthma symptoms
  - ☐ Decrease in oral corticosteroid use
  - ☐ Other: ____________________
- ☐ No. **Are you requesting an exception to the criteria?**
  - ☐ Yes. ***Rationale for exception***: ____________________
  - ☐ No

Priority Health Medicare Exception Request *(exceptions to the above criteria)*

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Dupixent likely be the most effective option for this patient?
- ☐ No
- ☐ Yes, because:____________________

____

____

If the patient is currently using Dupixent, would changing the patient's current regimen likely result in adverse effects for the patient?

☐ No
☐ Yes, because:____

____

____