Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Dupixent

Fax back to: (833) 605-4407
Phone: (215) 991-4300

Jefferson Health Plans 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 (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

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

Q1. Is the request for a new patient with current history of taking Dupixent in the last 90 days or is the request for reauthorization of prior approval?

☐ Yes ☐ No

Q2. Has the prescriber provided confirmation of disease stabilization or positive clinical response to Dupixent?

☐ Yes ☐ No

Q3. Will Dupixent be used concurrently with another monoclonal antibody therapy OR a Janus kinase (JAK) inhibitor (oral or topical)?

☐ Yes ☐ No

Q4. Is the drug prescribed by or in consultation with appropriate specialist for indication: a pulmonologist, allergist, immunologist, dermatologist, otolaryngologist, or gastroenterologist?

☐ Yes ☐ No

Q5. Is the patient within the age group listed in the FDA labeling for the requested indication?

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☐ Yes ☐ No

Q6. Is Dupixent being used for moderate-to-severe atopic dermatitis whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable?

☐ Yes ☐ No

Q7. For AD, are chart notes attached documenting inadequate response, intolerance, or contraindication to at least one topical corticosteroid AND at least one topical calcineurin inhibitor for patients 2 years of age and older OR at least one topical steroid for patients under the age of 2?

☐ Yes ☐ No

Q8. Is Dupixent being used for add on maintenance therapy for the treatment of moderate to severe asthma with eosinophilic type?

☐ Yes ☐ No

Q9. For asthma, are chart notes attached documenting a diagnosis of eosinophilic asthma including eosinophil count equal to or greater than 150 microliters? Labs must be attached.

☐ Yes ☐ No

Q10. Has the patient had at least one asthma exacerbation requiring systemic corticosteroids (e.g. prednisone) OR had an asthma-related hospitalization within the past 12 months?

☐ Yes ☐ No

Q11. Are chart notes attached documenting inadequate response, intolerance, or contraindication to both of the following medications: 1) medium-to-high-dose inhaled corticosteroid, AND 2) additional controller (e.g., LABA, LAMA, leukotriene modifier, or theophylline)?

☐ Yes ☐ No

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Q12. Is Dupixent being used for add on maintenance therapy for the treatment of oral corticosteroid dependent asthma with chart notes attached documenting the diagnosis?

☐ Yes ☐ No

Q13. Are chart notes attached documenting inadequate response, intolerance, or contraindication to both of the following medications: 1) high-dose inhaled corticosteroid AND 2) additional controller (e.g. LABA, LAMA, leukotriene modifier, or theophylline)?

☐ Yes ☐ No

Q14. Is Dupixent being used for add-on maintenance therapy treatment in patients with inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP)?

☐ Yes ☐ No

Q15. Are chart notes attached documenting chronic rhinosinusitis with nasal polyposis (CRSwNP) AND concurrent use of an intranasal corticosteroid?

☐ Yes ☐ No

Q16. Are chart notes attached documenting inadequate response, intolerance, or contraindication to at least one systemic corticosteroid therapy OR prior surgery for nasal polyps?

☐ Yes ☐ No

Q17. Is Dupixent being used for the treatment of allergic fungal rhinosinusitis with chart notes attached documenting the diagnosis?

☐ Yes ☐ No

Q18. Is there documentation of a history of sino-nasal surgery?

☐ Yes ☐ No

Q19. Are chart notes attached documenting inadequate response, intolerance, or contraindication to at least one inhaled nasal corticosteroid?

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☐ Yes ☐ No

Q20. Is Dupixent being used for the treatment eosinophilic esophagitis (EoE) with chart notes attached documenting the diagnosis?

☐ Yes ☐ No

Q21. For EoE, does the patient meet ALL of the following:

☐ Chart notes are attached documenting symptoms of esophageal dysfunction (e.g. dysphagia, GERD, heartburn, chest pain, abdominal pain)
☐ Patient has at least 15 intraepithelial eosinophils per high power (HPF) on biopsy
☐ Other causes of EoE have been excluded
☐ Chart notes are attached documenting inadequate response, intolerance, or contraindication to at least one proton pump inhibitor.
☐ Chart notes are attached documenting inadequate response, intolerance, or contraindication to one topical corticosteroid (swallowed inhaled fluticasone propionate, swallowed budesonide).

Q22. Is Dupixent being used for the treatment of prurigo nodularis and chart notes are attached documenting the diagnosis?

☐ Yes ☐ No

Q23. Is there documentation showing that the patient has pruritis lasting at least 6 weeks?

☐ Yes ☐ No

Q24. Is Dupixent being used as add-on maintenance treatment of adult patients with inadequately controlled chronic obstructive pulmonary disease (COPD) and an eosinophilic phenotype?

☐ Yes ☐ No

Q25. Are chart notes attached documenting a diagnosis of COPD with an eosinophilic phenotype including baseline eosinophil count greater than 300 cells/microL (lab results required)?

☐ Yes ☐ No

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Q26. Is there documentation showing the patient experienced EITHER of the following within the previous 12 months: (1) Two or more COPD exacerbations requiring systemic corticosteroids with or without antibiotics OR (2) a COPD exacerbation requiring hospitalization?

☐ Yes ☐ No

Q27. Is there documentation showing inadequate response, intolerance, or contraindication to at least one inhaled combination therapy (including LAMA/LABA or LAMA/LABA/ICS combination therapies)?

☐ Yes ☐ No

Q28. Is Dupixent being used for chronic spontaneous urticaria (CSU) with chart notes attached documenting the diagnosis? If YES, go to 29 , If NO, go to 32

☐ Yes ☐ No

Q29. Are notes attached confirming the patient has urticaria lasting more than 6 weeks?

☐ Yes ☐ No

Q30. Are there chart notes confirming that other forms of urticaria have been ruled out?

☐ Yes ☐ No

Q31. Are chart notes attached confirming patient remains symptomatic despite treatment with at least one H1 antihistamine treatment or has an intolerance or contraindication to at least one H1 antihistamine treatment?

☐ Yes ☐ No

Q32. Is Dupixent being used for the treatment of bullous pemphigoid (BP) with chart notes attached documenting the diagnosis?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q33. Are chart notes attached documenting inadequate response, contraindication, or intolerance to one systemic corticosteroid OR one immunosuppressive agent (e.g., azathioprine, cyclophosphamide, mycophenolate mofetil)?

☐ Yes ☐ No

_____ _____

Prescriber Signature Date

v2026

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