



MEDICAID / CHIP
PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Dupixent

Phone: 866-841-7659

Fax back to: 866-240-3712

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.

Member Name:		Prescriber Name:	
Member ID Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Member Phone Number:	NPI:	PA PROMISe ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Line of Business: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP	Specialty Pharmacy (if applicable):		
Drug Name:	Strength:		
Quantity:	Refills:		
Directions:			
Diagnosis Code:	Diagnosis:		
<i>Jefferson Health Plans' maximum approval time is 12 months but may be less depending on the criteria..</i>			

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. The request is for renewal of a prior authorization for Dupixent (dupilumab) that was previously approved. If YES, go to 20. If NO, go to 2.

Yes

No

Q2. The member is being treated for a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling or a medically accepted indication.

Yes

No

Q3. The member is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

Yes

No

Q4. The member is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

Yes

No

Q5. The member is prescribed Dupixent (dupilumab) by or in consultation with an appropriate specialist (e.g., pulmonologist, allergist, immunologist, dermatologist, hematologist/oncologist, rheumatologist, etc.).

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<input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>Q6. If currently using a different Monoclonal Antibody (MAB) - Anti-IL, Anti-IgE, Anti-TSLP, will discontinue the other MAB - Anti-IL, Anti-IgE, Anti-TSLP prior to starting Dupixent (dupilumab).</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
<p>Q7. If currently using a different targeted systemic Immunomodulators, Dermatologic (e.g., Adbry [tralokinumab], Cibinco [abrocitinib], Nemluvio [nemolizumab], Rinvoq [upadacitinib]), will discontinue the other targeted systemic Immunomodulators, Dermatologic prior to starting Dupixent (dupilumab).</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
<p>Q8. For a diagnosis of chronic atopic dermatitis, has atopic dermatitis associated with at least one of the following:</p> <p>a. A body surface area of 10% or greater that is affected, b. Involvement of critical areas (e.g., face, feet, genitals, hands, intertriginous areas, scalp), c. Significant disability or impairment of physical, mental, or psychosocial functioning</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
<p>Q9. For a diagnosis of chronic atopic dermatitis, has a history of therapeutic failure of or a contraindication or an intolerance to ONE of the following:</p> <p>a. A four-week trial of a low-potency topical corticosteroid for treatment of the face, skin folds, or other critical areas, b. For treatment of other areas, a four-week trial of a medium-potency or higher topical corticosteroid.</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>Q10. For a diagnosis of chronic atopic dermatitis, has a history of therapeutic failure of or a contraindication or an intolerance to an eight-week trial of a topical calcineurin inhibitor.</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	

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Q11. For a diagnosis of asthma, the member has asthma severity consistent with the FDA-approved indication for Dupixent (dupilumab) despite maximal therapeutic doses of or a contraindication or an intolerance to asthma controller drugs based on current national treatment guidelines for the diagnosis and management of asthma.

Yes No NA

Q12. For a diagnosis of asthma, ONE of the following:

a. Has an absolute blood eosinophil count 150 cells/microL
b. Is dependent on oral corticosteroids.

Yes No

Q13. The member will use Dupixent (dupilumab) in addition to standard asthma controller drugs as recommended by current national treatment guidelines.

Yes No

Q14. For a diagnosis of eosinophilic esophagitis, has a history of therapeutic failure of or a contraindication or an intolerance to a proton pump inhibitor.

Yes No NA

Q15. For a diagnosis of prurigo nodularis, the member has a history of pruritis lasting at least six weeks.

Yes No NA

Q16. The member has prurigo nodularis associated with at least one of the following:

a. greater than or equal to 20 nodular lesions
b. Significant disability or impairment of physical, mental, or psychosocial functioning;

Yes No

Q17. For a diagnosis of bullous pemphigoid, ONE of the following:

a. The member has a history of therapeutic failure of or a contraindication or an intolerance to

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systemic corticosteroids b. Has corticosteroid-dependent disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA

Q18. The member meets ONE of the following: a. Has a history of therapeutic failure of a corticosteroid-sparing therapy (e.g., doxycycline, dapsone, methotrexate, mycophenolate, azathioprine) b. Has a contraindication or an intolerance to corticosteroid-sparing therapies; <input type="checkbox"/> Yes <input type="checkbox"/> No
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Q19. For all other diagnoses, the member has a history of therapeutic failure of or a contraindication or an intolerance to first line therapy(ies) if applicable according to consensus treatment guidelines. <input type="checkbox"/> Yes <input type="checkbox"/> No
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Q20. The member is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature. <input type="checkbox"/> Yes <input type="checkbox"/> No

Q21. The member is prescribed Dupixent (dupilumab) by or in consultation with an appropriate specialist (e.g., pulmonologist, allergist, immunologist, dermatologist, hematologist/oncologist, rheumatologist, etc.). <input type="checkbox"/> Yes <input type="checkbox"/> No

Q22. The member has documented evidence of improvement in disease severity <input type="checkbox"/> Yes <input type="checkbox"/> No
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Q23. For a diagnosis of asthma, ONE of the following: a. Has documented measurable evidence of improvement in the severity of the asthma condition b. Has reduction of oral corticosteroid dose while maintaining asthma control
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<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
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Q24. The member continues to use Dupixent (dupilumab) in addition to standard asthma controller drugs as recommended by current national treatment guidelines.

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Q25. Additional Information:

Prescriber Signature

Date

v2026-06