PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS

Dupixent - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**.
Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Dupixent - Priority Partners MCO.

Drug Name (select from list of drugs shown)
DUPIXENT (dupilumab)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.

[If no, skip to question 4.]

2.	Is the requested drug being used to treat any of the following diagnoses: A) contact dermatitis, B) seborrheic dermatitis, C) lichen planus, D) lichen sclerosis, E) psoriasis, F) rosacea, or G) acne vulgaris?	Y N
	[If yes, no further questions.]	
3.	Will the patient use the requested drug concurrently with another biologic product?	Y N
	[If yes, no further questions.]	
	[If no, skip to question 45.]	
4.	Is the requested drug being used to treat any of the following diagnoses: A) contact dermatitis, B) seborrheic dermatitis, C) lichen planus, D) lichen sclerosis, E) psoriasis, F) rosacea, or G) acne vulgaris?	Y N
	[If yes, no further questions.]	
5.	Does the patient have a diagnosis of moderate-to-severe chronic atopic dermatitis?	Y N
	NOTE: Submission of medical records is required.	
	[If no, skip to question 18.]	
6.	Does the patient have a documented body surface area (BSA) coverage of 10 percent or greater?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
7.	Does the patient have documented functional impairment as a result of chronic atopic dermatitis, which can include limitation of activities of daily living (ex. consistent sleep disturbances, problems wearing clothing, skin infections, etc.)?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
8.	Has documentation been provided showing a baseline assessment using one of the following tools: A) Investigator's Static Global Assessment (ISGA) score, B) Eczema Area and Severity Index (EASI), C) Patient-Oriented Eczema Measure (POEM), or D) Scoring Atopic Dermatitis (SCORAD) index?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
9.	Does the patient have a documented history of treatment failure, contraindication, or intolerance to both of the following formulary alternatives: A) two medium to very-high potency topical corticosteroids, B) one topical calcineurin inhibitor [ex. Elidel (pimecrolimus) or Protopic (tacrolimus)]?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	

10. Does the patient have moderate disease?	Y N	
[If no, skip to question 12.]		
11. Does the patient have documentation of trial and inadequate response to Eucrisa (crisaborole)?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
12. Is the request for a pediatric patient?	Y N	
[If yes, skip to question 15.]		
13. Has the patient had trial and inadequate response to phototherapy, unless such use is not advised (i.e., patient has a history of skin cancer, currently taking medication that may be photosensitizing, etc.)?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
14. Has the patient had trial and inadequate response to at least one of the following systemic agents traditionally used for refractory disease, or has a contraindication to systemic therapy: A) cyclosporine, B) methotrexate, C) mycophenolate mofetil, D) azathioprine?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
15. Is the patient being concomitantly treated with other biologics (Enbrel, Xolair, Rituxan, Adbry etc.) or janus kinase (JAK) inhibitors (Cibinqo, Rinvoq, etc.) that are indicated for the treatment of atopic dermatitis?	Y N	
[If yes, no further questions.]		
16. Is the prescriber one of the following specialists: A) allergist, B) dermatologist, or C) immunologist?	Y N	
[If no, no further questions.]		
17. Is the patient 6 months of age or older?	Y N	
[If yes, skip to question 44.]		
[If no, no further questions.]		
18. Is the requested drug being used as an add-on maintenance treatment for moderate-to severe asthma with an eosinophilic phenotype?	Y N	
NOTE: Submission of medical records is required.		
[If no, skip to question 23.]		
19. Does the patient have a blood eosinophil count of at least 300 cells per microliter in the past 12 months?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
20. Does the patient have documented poorly controlled asthma as evidenced by two or more exacerbations in the	Y N	

past 12 months despite the use of high-dose inhaled corticosteroids (ICS) as applicable for either of the following: A) for ages 12 to 17 years, ICS dose must be 440 micrograms per day (mcg/day) or greater of fluticasone propionate (FP) (ex-actuator) or equivalent daily, or the mid-strength approved maintenance dose of inhaled corticosteroid-long-acting beta-agonist (ICS-LABA) combinations, B) for 18 years of age and older, ICS dose must be 880 mcg/day or greater of fluticasone propionate (FP) (ex-actuator) or equivalent daily, or the highest approved maintenance dose of ICS-LABA combinations?		
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
21. Does the patient have documented treatment with at least 2 other controllers in addition to an inhaled corticosteroid (ICS) or an inhaled corticosteroid-long-acting beta-agonist (ICS-LABA) combination (i.e., long-acting beta-agonist [if not already using an ICS-LABA combination], an asthma-indicated long-acting anticholinergic agent, leukotriene modifier, or theophylline), for at least 6 months, and demonstrated adherence of 80 percent or greater?	Y N	
NOTE: Submission of medical records is required.		
[If yes, skip to question 28.]		
22. Does the patient have a documented allergy, contraindication, or an intolerance to any of the following specified prerequisite agents: A) long-acting beta-agonist (if not already using an inhaled corticosteroid-long-acting beta-agonist [ICS-LABA]) combination, B) an asthma-indicated long-acting anticholinergic agent, C) leukotriene modifier, D) theophylline?	Y N	
NOTE: Submission of medical records is required.		
[If yes, skip to question 28.]		
[If no, no further questions.]		
23. Is the requested drug being used as an add-on maintenance treatment for moderate-to severe oral corticosteroid-dependent asthma?	Y N	
NOTE: Submission of medical records is required.		
[If no, skip to question 30.]		
24. Has the patient had documented use of daily oral corticosteroid for at least one month within the last 3 months?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
25. Does the patient have documented poorly controlled asthma as evidenced by two or more exacerbations in the past 12 months despite the use of high-dose inhaled corticosteroids (ICS) as applicable for either of the	Y N	

following: A) for ages 12 to 17 years, ICS dose must be 440 micrograms per day (mcg/day) or greater of fluticasone propionate (FP) (ex-actuator) or equivalent daily, or the mid-strength approved maintenance dose of inhaled corticosteroid-long-acting beta-agonist (ICS-LABA) combinations, B) for ages 18 years and older, ICS dose must be 880 mcg/day or greater of fluticasone propionate (FP) (ex-actuator) or equivalent daily, or the highest approved maintenance dose of ICS-LABA combinations?		
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
26. Does the patient have documented treatment with at least 2 other controllers in addition to an inhaled corticosteroid (ICS) or an inhaled corticosteroid-long-acting beta-agonist (ICS-LABA) combination (i.e., long-acting beta-agonist [if not already using an ICS-LABA combination], an asthma-indicated long-acting anticholinergic agent, leukotriene modifier, or theophylline), for at least 6 months, and demonstrated adherence of 80 percent or greater?	Y N	
NOTE: Submission of medical records is required.		
[If yes, skip to question 28.]		
27. Does the patient have a documented allergy, contraindication, or an intolerance to any of the following specified prerequisite agents: A) long-acting beta-agonist (if not already using an inhaled corticosteroid-long-acting beta-agonist (ICS-LABA) combination, B) an asthma-indicated long-acting anticholinergic agent, C) leukotriene modifier, D) theophylline?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
28. Is the prescriber one of the following specialists: A) allergist, B) immunologist, or C) pulmonologist?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
29. Is the patient 6 years of age or older?	Y N	
[If yes, skip to question 44.]		
[If no, no further questions.]		
30. Is the requested drug being used as an add-on maintenance treatment of chronic rhinosinusitis with nasal polyposis (CRSwNP)?	Y N	
NOTE: Submission of medical records is required.		
[If no, skip to question 33.]		
31. Does the patient have a documented diagnosis of inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP) and any of the following: A) nasal congestion and discharge, B) breathing difficulties, C)	Y N	

reduced or loss of sense of smell and taste, or D) facial pressure?		
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
32. Is there documentation showing ONE of the following: A) the patient continues to have symptoms after sino-nasal surgery, B) the patient has had a trial and inadequate response to one oral corticosteroid and one nasal corticosteroid regimen?	Y N	
NOTE: Submission of medical records is required.		
[If yes, skip to question 43.]		
[If no, no further questions.]		
33. Does the patient have a documented diagnosis of eosinophilic esophagitis (EoE) supported by endoscopic biopsy?	Y N	
NOTE: Submission of medical records is required.		
[If no, skip to question 40.]		
34. Are there baseline esophageal endoscopic biopsies showing eosinophil-predominant inflammation as evidence by greater than or equal to 15 intraepithelial eosinophils per high-power field?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
35. Is there a baseline Dysphagia Symptom Questionnaire (DSQ) score to support severity of disease?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
36. Does the patient have a history of an average of at least 2 episodes of dysphagia with solid foods per week?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
37. Has the patient had a documented trial and inadequate response to at least one first-line treatment agent (proton pump inhibitors [PPIs] or topical glucocorticoids)?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
38. Is the prescriber one of the following specialists: A) allergist, or B) gastroenterologist?	Y N	
[If no, no further questions.]		
39. Is the patient 12 years of age or older and weighs at least 40 kg (88 lbs.)?	Y N	
[If yes, skip to question 44.]		
[If no, no further questions.]		

40. Does the patient have a documented diagnosis of prurigo nodularis (PN) supported by documentation showing both of the following: A) patient has an average worst itch score of greater than or equal to 7 on the Worst Itch-Numeric Rating Scale (WI-NRS), and B) patient has greater than or equal to 20 nodular lesions?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
41. Has documentation been submitted showing trial and inadequate response, or contraindication to, both of the following: A) two or more medium-to-superpotent topical corticosteroids, and B) topical emollients?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
42. Is the prescriber a dermatologist?	Y N	
[If no, no further questions.]		
43. Is the patient 18 years of age or older?	Y N	
[If no, no further questions.]		
44. Will the requested drug be used concurrently with another biologic?	Y N	
[No further questions.]		
45. Does the patient have a diagnosis of atopic dermatitis?	Y N	
[If no, skip to question 48.]		
46. Is there specific documentation of a score reduction using ONE of the following clinical evaluation tools: A) Investigator's Static Global Assessment (ISGA) decrease from baseline by at least 2 points, B) Eczema Area and Severity Index (EASI) decrease from baseline by at least 75%, C) Patient-Oriented Eczema Measure (POEM) decrease from baseline by at least 3 points, D) Scoring Atopic Dermatitis (SCORAD) decrease from baseline by at least 50%?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
47. Is the patient 6 months of age or older?	Y N	
[No further questions.]		
48. Does the patient have a diagnosis of asthma?	Y N	
[If no, skip to question 51.]		
49. Is there specific documentation of ONE of the following: A) reduction in asthma symptoms (wheezing, coughing, shortness of breath, chest tightness), B) reduction in administration frequency of short-acting rescue medication, C) reduction in exacerbation frequency and asthma-related hospitalizations (no increase in inhaled or oral	Y N	

corticosteroid dose), D) elevation in predicted forced expiratory volume in one second (FEV1) from the patient's baseline before treatment?		
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
50. Is the patient 6 years of age or older?	Y N	
[No further questions.]		
51. Does the patient have a diagnosis of chronic rhinosinusitis with nasal polyposis?	Y N	
[If no, skip to question 53.]		
52. Is there specific documentation of ONE of the following: A) reduction in the use of systemic corticosteroids, B) reduction in the use of nasal corticosteroids?	Y N	
NOTE: Submission of medical records is required.		
[If yes, skip to question 58.]		
[If no, no further questions.]		
53. Does the patient have a diagnosis of eosinophilic esophagitis?	Y N	
[If no, skip to question 56]		
54. Is there specific documentation of ONE of the following: A) reduction in esophageal intraepithelial eosinophil count to less than or equal to 6 eosinophils per high-power field (eos/hpf), B) reduction in Dysphagia Symptom Questionnaire (DSQ) score from baseline?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
55. Is the patient 12 years of age or older and weighs at least 40 kg (88 lbs.)?	Y N	
[No further questions.]		
56. Does the patient have a diagnosis of prurigo nodularis?	Y N	
[If no, no further questions.]		
57. Is there specific documentation of ONE of the following: A) Worst Itch-Numeric Rating Scale (WI-NRS) decrease from baseline by at least 4 points, B) Investigator's Global Assessment for Prurigo Nodularis-Stage (IGA PN-S) reduction in nodules reflected score of 0 or 1 (equivalent of 0-5 nodules)?	Y N	
[If no, no further questions.]		
58. Is the patient 18 years of age or older?	Y N	

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a

state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date