Priority Partners MCO
7231 Parkway Drive, Suite 100
Hanover, MD 21076

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

Prior Authorization

JOHNS HOPKINS HEALTHCARE (MEDICAID)

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 Healthcare at **1-410-424-4607**.
Please contact Johns Hopkins Healthcare 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 29.]	
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 atopic dermatitis?	Y N
	NOTE: Submission of medical records is required.	
	[If no, skip to question 11.]	
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.	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
	[If no, no further questions.]	
9.	Is the patient being concomitantly treated with additional biologic medication (Enbrel, Xolair, Rituxan, etc.) for the treatment of atopic dermatitis?	Y N
	[If yes, no further questions.]	
10.	Is the requested drug being prescribed by one of the following specialists: A) allergist, B) dermatologist, or C) immunologist?	Y N
	[If yes, skip to question 22.]	
	[If no, no further questions.]	

11. 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 16.]		
12. 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.]		
13. Does the patient have documented poorly controlled asthma as evidenced by two or more exacerbations in the past 12 months experience 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) of fluticasone propionate (FP) (ex-actuator) or equivalent daily, or 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?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
14. 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 21.]		
15. 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 21.]		
[If no, no further questions.]		
16. 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 24.]		
17. Has the patient had documented use of daily oral corticosteroid for at least one month within the last 3 months?	Y N	
[If no, no further questions.]		
18. Does the patient have documented poorly controlled asthma as evidenced by two or more exacerbations in the past 12 months experience 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) of fluticasone propionate (FP) (ex-actuator) or equivalent daily, or 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?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
19. 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 21.]		
20. 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.]		
21. Has the patient had an allergy, immunology, or a pulmonary consult?	Y N	
NOTE: Submission of medical records is required.		
[If yes, skip to question 23.]		
[If no, no further questions.]		
22. Is the patient 6 years of age or older?	Y N	

[If yes, skip to question 28.]		
[If no, no further questions.]		
23. Is the patient 12 years of age or older?	Y N	
[If yes, skip to question 28.]		
[If no, no further questions.]		
24. 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, no further questions.]		
25. 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) reduced or loss of sense of smell and taste, or D) facial pressure?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
26. 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	
[If no, no further questions.]		
27. Is the patient 18 years of age or older?	Y N	
[If no, no further questions.]		
28. Will the requested drug be used concurrently with another biologic?	Y N	
[No further questions.]		
29. Does the patient have a diagnosis of atopic dermatitis?	Y N	
[If no, skip to question 31.]		
30. Has the patient experienced positive clinical response to therapy with the requested drug?	Y N	
NOTE: Submission of medical records is required.		
[No further questions.]		
31. Does the patient have a diagnosis of asthma?	Y N	
[If no, skip to question 33.]		
32. Is there specific documentation for 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 corticosteroid dose), D) elevation in predicted forced	Y N	

expiratory volume in one second (FEV1) from the patient's baseline before treatment?	
[No further questions.]	
33. Does the patient have a diagnosis of chronic rhinosinusitis with nasal polyposis?	Y N
[If no, no further questions.]	
34. Is there specific documentation for ONE of the following: A) reduction in the use of systemic corticosteroids, B) reduction in the use of nasal corticosteroids?	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