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United Healthcare Community Plan

**COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES**

**Service Authorization (SA) Form**

**Dupixent®**

If the following information is not coplete, correct, or legible, the SA process can be delayed.

Please use one form per member.

**Dupixent for atopic dermatitis has an electronic edit and does not require submission of this fax form; this form is for other indications. Length of Authorization = 1 year.**

## MEMBER INFORMATION

**Last Name:** _____

**First Name:** _____

**Medicaid ID Number:** _____

**Date of Birth:** _____

**Expected Pregnancy Term Date:** _____

**Requested Start Date:** _____

**Weight in Kilograms**: _____

## PRESCRIBER INFORMATION

**Last Name:** _____

**First Name:** _____

**NPI Number:** _____

**Phone Number:** _____

**Fax Number:** _____

## DIAGNOSIS AND MEDICAL INFORMATION

**For a diagnosis of chronic rhinosinusitis with nasal polyps only:**

1. Is the member 12 years of age or older?
   ☐ Yes ☐ No
2. Does the member have inadequate response after 3 consistent months' use of preferred intranasal steroids or oral corticosteroids?
   ☐ Yes ☐ No
3. Is the member concurrently being treated with intranasal corticosteroids?
   ☐ Yes ☐ No
4. Has the physician assessed baseline disease severity utilizing an objective measurement/tool?
   ☐ Yes ☐ No

*(Form continued on next page)*

**Member's Last Name:** **Member's First Name:**

**For a diagnosis of moderate to severe asthma:**

1. Is the member 6 years of age or older?
   ☐ Yes ☐ No
2. Does the member have a diagnosis of moderate to severe asthma with either:
   - Asthma with eosinophilic phenotype with eosinophil count ≥ 150 cells/mcL; **OR**
   - Oral corticosteroid-dependent asthma with at least 1 month of daily oral corticosteroid use within the last 3 months

   ☐ Yes ☐ No

**For a diagnosis of eosinophilic esophagitis (EoE):**

1. Is the member 1 year of age or older?
   ☐ Yes ☐ No
2. Does the member weigh ≥ 15 kg?
   ☐ Yes ☐ No
3. Is Dupixent prescribed by or in consultation with an allergist or gastroenterologist?
   ☐ Yes ☐ No
4. Has the member responded clinically to treatment with a topical glucocorticosteroid or proton pump inhibitor?
   ☐ Yes ☐ No

**For adult members with inadequately controlled chronic obstructive pulmonary disease (COPD) and an eosinophilic phenotype:**

1. Is the member 18 years of age or older?
   ☐ Yes ☐ No
2. Is Dupixent prescribed by or in consulation with a pulmonologist?
   ☐ Yes ☐ No
3. Does the member have a diagnosis of COPD that is inadequately controlled and a minimum blood eosinophil count of 300 cells/mcL at screening, measured within the past 12 months?
   ☐ Yes ☐ No
4. Is the member receiving maximal inhaled therapy consisting of a long-acting muscarinic antagonist (LAMA), long-acting beta agonist (LABA), and inhaled corticosteroid (ICS) (or therapy of LAMA plus LABA if ICS is contraindicated)?
   ☐ Yes ☐ No
5. Does the member have a history of at least 2 moderate (requiring treatment with systemic corticosteroids and/or antibiotics) or 1 severe exacerbation(s) (resulting in hospitalization or observation for over 24 hours in an emergency department or urgent care facility) in the previous year, with 1 exacerbation occurring while the member was on maximal inhaled therapy?
   ☐ Yes ☐ No

**Member's Last Name: Member's First Name:**

**For adult members with a diagnosis of prurigo nodularis (PN):**

1. Is the member 18 years of age or older?
   ☐ Yes ☐ No
2. Does the member have a diagnosis of PN?
   ☐ Yes ☐ No
3. Is Dupixent prescribed by or in consultation with a dermatologist, allergist, or immunologist?
   ☐ Yes ☐ No

**For renewal:**

1. Has the member experienced a therapeutic benefit from the requested medication?
   ☐ Yes ☐ No
2. Is the member free of toxicity from the requested medication?
   ☐ Yes ☐ No

**Prescriber Signature (Required)** **Date**

By signature, the Physician confirms the above information is accurate and verifiable by patient records.

**Please include ALL requested information; Incomplete forms will delay the SA process.**

Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

Fax this form to 1-866-940-7328

Pharmacy PA call center: 1-800-310-6826