Sentara Health Plans

Would you like to use electronic prior authoriztion? Consider using Surescripts, our electronic prior authorization portal at providerportal.surescripts.net/ProviderPortal/login OR fax completed prior authorization request form to 800-750-9692.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at sentarahealthplans.com/en/providers/authorizations/prescription-drugs

Dupixent (Medicare)

REQUIRED: Office notes, labs, and medical testing relevant to request showing medical justification to support diagnosis

Member Information

Member Name (first & last):	Date of Birth:	Gender: ☐Male ☐Female	Height:
Member ID:	City:	State:	Weight:

Prescribing Provider Information

Requestor's Name:	Requestor's Phone Number:	Requestor's Fax Number:	
Provider Name (first & last):	Specialty	NPI:	DEA:
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone:	Office Fax:	

Dispensing Provider/Pharmacy Information

Place of Administration:	☐Self-Administered ☐Physician's Office ☐Home ☐Home Infusion Center ☐Outpatient Infusion Center Name: _____

Agency NPI:	Agency Name:	Agency Phone Number:
Agency Address		Agency Fax Number:
City:	State:	Zip:

Dispensing Location:	☐Retail Pharmacy ☐Mail Order ☐Physician's Office ☐Specialty Pharmacy ☐Other

Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:
Pharmacy NPI:		

Requested Medication Information

Medication request is NOT for an FDA approved, or compendia-supported diagnosis (check one): ☐Yes ☐No	Diagnosis:	ICD-10 Code:
Are there any contraindications to formulary medications? If yes, please specify:	Is this a New Request or Continuation of Therapy: ☐New, start date: __/__/_____ ☐Continuation, date of last treatment: __/__/_____	
Directions for Use:	Strength:	Dosage Form
	Duration:	Quantity: / Days Supply:

What medication(s) has the member tried and failed for this diagnosis? Please specify below including duration of treatment.

Turn-Around Time for Review:

☐Standard ☐Urgent: Waiting standard time for decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision.

Signature: _____

Sentara Health Plans Member First Name: _____ Member Last Name: _____

Member ID: _____ Member Date of Birth: _____

Clinical Information:

** Indicate questions that are required to be answered*

Q1. Please select applicable diagnosis: *

- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Chronic Spontaneous Urticaria (CSU)
- ☐ Eosinophilic Esophagitis (EOE)
- ☐ Prurigo Nodularis (PN)
- ☐ Atopic Dermatitis (AD)
- ☐ Asthma
- ☐ Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)
- ☐ Other

Q2. For COPD: Which of the following has the member met?

- ☐ Labs submitted showing a blood eosinophils at least 300 cells per microliter taken within previous 6 weeks or prior to monoclonal antibody therapy
- ☐ FEV1/FVC ratio less than 0.7 and FEV1 at least 30% but not more than 80% post-bronchodilator
- ☐ Currently treated with triple or dual therapy (long-acting beta-2 agonist (LABA)/long-acting muscarinic antagonists (LAMA)/ inhaled corticosteroid (ICS) or ong-acting muscarinic antagonists (LAMA)/long-acting beta-2 agonist (LABA)) for at least 3 months
- ☐ Has signs or symptoms of chronic bronchitis for at least 3 months in the previous 12 months

Q3. For COPD: Has the member experienced COPD exacerbations in the past 12 months meeting ONE of the following?

- ☐ 2 or more episodes requiring treatment with oral corticosteroids or antibiotics
- ☐ Episode required hospitalization

Q4. For COPD: Will the member continue using dual or triple therapy while on requested medication?

- ☐ Yes
- ☐ No

Q5. For CSU: Does the member have documentation of the following?

- ☐ Urticaria present for no less than 6 weeks
- ☐ Member experiences spontaneous occurrence of wheals or hives that are pruritic in nature, not painful, more than 3 days per week
- ☐ Symptoms persist despite taking doses of second generation H1-antihistamines (e.g. cetirizine) AND a leukotriene receptor antagonist (i.e. montelukast) for at least two weeks

Q6. For EOE: Has diagnosis been confirmed by endoscopic biopsy showing at least 15 intraepithelial eosinophils per hpf?

- ☐ Yes
- ☐ No

Q7. For EOE: Have secondary causes have been ruled out?

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☐ Yes	☐ No
Q8. For EOE: Has the member tried and failed 8 weeks therapy with a prescription strength Proton Pump Inhibitor (i.e. omeprazole 40 mg)?	
☐ Yes	☐ No
Q9. For PN: Does the member have at least 20 nodular lesions and has experienced 6 weeks of pruritus?	
☐ Yes	☐ No
Q10. For Reauthorization: Has the member responded positively to therapy as determined by the prescribing physician?	
☐ Yes	☐ No
Q11. For Asthma: Which of the following has the member met? ☐ Member has a blood eosinophil at least 150 cells per microliter w/in prior 6 weeks OR has oral corticosteroid-dependent asthma ☐ Member has received both an inhaled corticosteroid AND an adjunct maintenance medication (i.e. montelukast) (Note: Exception to the requirement for a trial of an asthma maintenance medication can be made if already established on monoclonal antibodies used concomitantly w/an inhaled corticosteroid ☐ Asthma is uncontrolled defined by member experiencing one of the following (A, B, C, D, or E): A) 2 or more asthma exacerbations requiring treatment with systemic corticosteroid in last 12 months, B) 1 or more asthma exacerbations requiring hospital or emergency department visit in last 12 months, C) FEV1 less than 80% predicted, D) FEV1/FVC less than 0.80, OR E) asthma worsens with tapering of oral corticosteroid.	
Q12. For Asthma: Will the member continue to receive treatment with 1 inhaled corticosteroid or 1 inhaled corticosteroid-containing combo inhaler?	
☐ Yes	☐ No
Q13. For CRSwNP: Is the member receiving treatment with an intranasal corticosteroid and experiencing rhinosinusitis symptoms like nasal obstruction, rhinorrhea, or reduction/loss of smell?	
☐ Yes	☐ No
Q14. For CRSwNP: Has the member received treatment within previous 2 yrs or has contraindication to systemic corticosteroid treatment OR if member had prior surgery for nasal polyps?	
☐ Yes	☐ No
Q15. For CRSwNP: Will the member continue to receive treatment with an intranasal corticosteroid while on the requested medication?	

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☐ Yes	☐ No