GHP Family Pharmacy Customer Service
100 N. Academy Ave.
Danville, PA 17822
Tel. • 855•552•6028 PA Relay 711 GeisingerHealthPlan.com

Geisinger

DUPIXENT (dupilumab) PRIOR AUTHORIZATION FORM *(form effective 01/03/2022)*

Prior authorization guidelines for **Dupixent** and **Quantity Limits/Daily Dose Limits** are available on Geisinger Health Plan's website at https://healthplan.geisinger.org/pharmacy/pharmacy.aspx?strip=true&style=OneGeisinger

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested: Dupixent	Strength/formulation:	Weight: _____ lbs / kg	
Directions:		Quantity:	Refills:
Diagnosis (*submit documentation*):		Diagnosis code (*required*):	
For a diagnosis of asthma, is Dupixent being prescribed by or in consultation with a specialist?		☐Yes ☐No	*Submit documentation of consultation if applicable.*

INITIAL requests

☐***For the treatment of atopic dermatitis:*** Which of the following treatments have been tried (or cannot be tried due to intolerance or contraindication) by the beneficiary? *Check all that apply. SUBMIT DOCUMENTATION for each.*

- ☐For the face or skin folds, low-potency (or higher) topical corticosteroids
- ☐For other body areas, a topical corticosteroid with a potency appropriate for the beneficiary's age and affected area(s) of the body
- ☐Elidel (pimecrolimus) or Protopic (tacrolimus)
- ☐Phototherapy / photochemotherapy (e.g., PUVA, UVB light)
- ☐Systemic immunosuppressives (e.g., azathioprine, cyclosporine, methotrexate, mycophenolate)

☐***For the treatment of asthma:*** Indicate which of the following apply to the beneficiary. *Check all that apply. SUBMIT DOCUMENTATION for each.*

- ☐Has a diagnosis of asthma with an eosinophilic phenotype with an absolute blood eosinophil count ≥ 150 cells/microliter
- ☐Has a diagnosis of oral corticosteroid-dependent asthma
- ☐Has asthma that is moderate-to-severe
- ☐Has tried or cannot use standard asthma controller medications (e.g., inhaled corticosteroids, inhaled long-acting beta agonists (LABAs), etc.)
- ☐Will use Dupixent in addition to tolerated standard asthma controller medications (e.g., inhaled corticosteroids, inhaled LABAs, etc.)

☐***For treatment of chronic rhinosinusitis with nasal polyposis:*** *Check all that apply. SUBMIT DOCUMENTATION for each.*

- ☐Will use Dupixent as an add-on maintenance treatment for inadequately controlled chronic rhinosinusitis with nasal polyposis

RENEWAL requests

Since starting Dupixent, did the beneficiary experience a positive clinical response and/or improvement in disease severity?	☐Yes ☐No	*Submit documentation of clinical response.*

Please submit to PromptPA https://ghp.promptpa.com OR fax to Geisinger Health Plan at 570-271-5610 the completed form with required clinical documentation.

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Prescriber Signature:	**Date**: