Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

Dupixent (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois at **1-844-242-0908**.
When conditions are met, we will authorize the coverage of Dupixent (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

Dupixent (dupilumab)

Other, please specify_____

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: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis:_____ ICD Code:_____

Please circle the appropriate answer for each question.

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

   [If no, skip to question 5.]

2. Has the patient experienced at least 20% symptom improvement (e.g., reduction in lesions)? Y N

   [If yes, skip to question 4.]

3. Does the patient have an Investor's Static Global Assessment (ISGA) of 0 or 1 ('clear' or 'almost clear')? Y N

[If no, then no further questions.]

4. Is the patient compliant with treatment? Y N

   [No further questions.]

5. Does the patient have diagnosis of moderate to severe atopic dermatitis? Y N

   [If no, then no further questions.]

6. Is the medication prescribed by, or after consultation with, a dermatologist or allergist or immunologist? Y N

   [If no, then no further questions.]

7. Has the patient had an inadequate response or intolerable side effects to two preferred (medium to very high potency) topical corticosteroids (e.g. triamcinolone, clobetasol, mometasone, betamethasone, fluocinonide)? Y N

   Please document medications tried:

   _____

   [If no, then no further questions.]

8. Has the patient had an inadequate response or intolerable side effects to one topical calcineurin inhibitor (e.g., tacrolimus)? Y N

   Please document medication(s) tried:

   _____

   [If no, then no further questions.]

9. Is the patient at least 18 years of age? Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature Date