Pharmacy Prior Authorization

AETNA BETTER HEALTH NEW JERSEY (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 New Jersey at **1-855-296-0323**.
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 *(circle drug)*

Dupixent (dupilumab)

Other, specify drug _____

Quantity _____ Frequency _____ Strength _____

Route of administration _____ Expected length of therapy _____

Member information

Member name: _____

Member ID: _____

Member Group No.: _____

Member DOB: _____

Member phone: _____

Prescribing physician

Physician name: _____

Specialty: _____ NPI number: _____

Physician fax: _____ Physician phone: _____

Physician address: _____ City, state, zip: _____

Diagnosis: _____ **ICD Code:** _____

Circle the appropriate answer for each question.

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

   [If no, skip to question 3.]

2. Does the member meet any of the following criteria: A) member responded to medication therapy (for example, had reduction in lesions) or B) member has Investor's Static Global Assessment (ISGA) score of 0 or 1 ('clear' or 'almost clear')? Y N

   [No further questions.]

3. Does the member have a diagnosis of moderate to severe atopic dermatitis? Y N

[If no, then no further questions.]

4. Has the member had a baseline evaluation of the condition using Patient-Oriented Eczema Measure (POEM) with a score greater than or equal to 8? Y N

   [If no, then no further questions.]

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

   [If no, then no further questions.]

6. Has the member had an inadequate response or intolerable side effects to two preferred (medium to very high potency) topical corticosteroids (for example, triamcinolone, clobetasol, mometasone, betamethasone, fluocinonide)? Y N

   Please document medications tried: _____

   [If yes, skip to question 8.]

7. Are both of the following statements true: A) member's condition affects sensitive areas such as the face, and B) member had an inadequate response or intolerable side effects to at least one preferred low potency topical corticosteroid? Y N

   [If no, then no further questions.]

8. Has the member had an inadequate response or intolerable side effects to both of the following: A) tacrolimus and B) Elidel? Y N

   Please document medication(s) tried: _____

   [If no, then no further questions.]

9. Has the member had an inadequate response or intolerable side effects to at least one oral systemic therapy such as methotrexate (MTX), cyclosporine, azathioprine or mycophenolate? Y N

   [If no, then no further questions.]

10. Is the member 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**