Pharmacy Prior Authorization

AETNA BETTER HEALTH FLORIDA

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 Florida at **1-855-799-2554**.
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 _____

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:** _____

Circle the appropriate answer for each question.

1. Is the patient 18 years of age or older? Y N

   [If no, no further questions.]

2. Does the patient have a documented diagnosis of atopic dermatitis? Y N

   [If no, no further questions.]

3. Will Dupixent be used in combination with other biologics (e.g., Xolair, Remicade, Enbrel, Humira, etc.)? Y N

   [If yes, no further questions.]

4. Does the patient have a parasitic infection? Y N

   [If yes, no further questions.]

5. Is the request for continuation of therapy? Y N

   [If yes, skip to question 8.]

6. Has the patient had a trial of at least one preferred medium to very-high potency topical steroid and experienced inadequate response or intolerance? Y N

   [If no, no further questions.]

7. Has the patient had a trial of at least one preferred topical calcineurin inhibitor and experienced inadequate response or intolerance? Y N

   [No further questions]

8. Is there documentation of positive clinical response: clinical reduction in pruritus and flares? 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**