

Ticket #: _____ Request Date: _____ Request Time: _____

Dupixent® Prior Authorization Request Form
 DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED.

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)			
Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

Clinical Information (required)	
Select the diagnosis below:	
<input type="checkbox"/> Moderate to severe chronic atopic dermatitis	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	

Clinical Information:

For patients with moderate-to-severe asthma: (All questions below MUST be answered)

- Is the patient 12 years of age or older? Yes No
- A pretreatment forced expiratory volume in 1 second (FEV₁) less than or equal to (≤) 90% predicted? Yes No
- Has a blood eosinophil count (in the absence of other potential causes of eosinophilia, including hypereosinophilic syndromes, neoplastic disease, and known or suspected parasitic infection) greater than or equal to 150 cells/microliter [1 microliter (μL) is equal to 1 cubic millimeter (mm³)] at initiation of therapy? Yes No
- Patient has had a 3-month trial and inadequate response or intolerance to combination controller therapy (medium-to-high dose inhaled corticosteroids) plus long acting beta2-agonists, leukotriene modifiers, theophylline or oral corticosteroids? Yes No
- Patient has oral corticosteroid dependent asthma? Yes No
- Patient has had 3-months' trial and inadequate response or intolerance to high dose inhaled corticosteroid with daily oral glucocorticoids given in combination with a controller medication (either a long-acting beta2-agonist or leukotriene receptor antagonist or theophylline)? Yes No
- Patient has experienced two or more asthma exacerbations in the prior 12 months requiring use of systemic corticosteroid OR temporary increase in the patient's usual maintenance dosage of oral corticosteroids? Yes No

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For continuation of therapy/reauthorization: (All questions below MUST be answered)

- Has the patient experienced decreased utilization of rescue medications? Yes No
- Has the patient experienced decreased frequency of exacerbations (defined as worsening of asthma that requires an increase in inhaled corticosteroid dose or treatment with systemic corticosteroids)? Yes No
- Has the patient increased in predicted FEV₁ from pretreatment baseline? Yes No
- Has reduction in reported asthma-related symptoms, such as, asthmatic symptoms upon awakening, coughing, fatigue, shortness of breath, sleep disturbance or wheezing? Yes No

For the treatment of atopic dermatitis: (All questions MUST be answered)

- Is the patient 12 years of age or older? Yes No
- Does the patient have a diagnosis of moderate-to-severe atopic dermatitis? Yes No
- Does the patient have chronic atopic dermatitis that has been present for 3 years or more? Yes No
- Has the patient failed topical pharmacological therapy as indicated by one or more of the following:
 - Daily treatment of topical corticosteroids of medium to higher potency for the maximum treatment period indicated in the product prescribing information has failed to achieve and maintain remission of low or mild disease activity state? Yes No
 - Topical calcineurin inhibitors if topical corticosteroids are not indicated, for the maximum treatment period indicated in the product prescribing information has failed to achieve and maintain remission of low or mild disease activity state? Yes No
 - Topical treatment is medically inadvisable as defined by treatments which have side effects or safety concerns which outweigh potential treatment benefits as evidenced by ANY of the following (**check all that apply**): Yes No
 - Intolerance to treatment
 - Hypersensitivity reactions
 - Significant skin atrophy
 - Systemic effects

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Authorized Medical Signature:	
Telephone:	Date:

When Completed Return To:

MC-Rx Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507
1-866-965-Drug (3784) / Fax # 866-999-7736

Please note: This request may be denied unless all required information is received.

Please note that this form is to be completed by the prescribing physician. This document and others, if attached, contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**
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