MC-Rx
Powered by ProCare Rx

Dupixent®

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

Dupixent® Prior Authorization Request Form

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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:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Moderate to severe chronic atopic dermatitis

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Select if Dupixent is prescribed by or in consultation with one of the following specialists:

- ❑ Dermatologist
- ❑ Allergist/immunologist

Does the patient have history of failure, contraindication, or intolerance to one medium to high potency topical corticosteroid? ❑ **Yes** ❑ **No**

Select if the patient has history of failure or intolerance to the following, unless the patent is not a candidate for therapy (e.g., immunocompromised):

- ❑ Elidel (pimecrolimus) topical cream
- ❑ Tacrolimus topical ointment

Reauthorization:

If this is a reauthorization request, answer the following question:

Is there documentation the patient has had a positive clinical response to Dupixent therapy (e.g., reduction in body surface area involvement, reduction in pruritus severity)? ❑ **Yes** ❑ **No**

Quantity Limit Requests:

What is the quantity requested per MONTH? _____

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Other: _____

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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.