MC-Rx
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Dupixent®

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)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
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:

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 (FEV_1) 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 (mm^3)] 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 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**

Dupixent® Prior Authorization Request Form (Page 2 of 2)

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 FEV_1 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 6 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.