



Please complete ALL information below and fax your request to 1-888-671-5285

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:
Is generic substitution acceptable? <input type="checkbox"/> Yes <input type="checkbox"/> No		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

Clinical Information (required)

Select the diagnosis below:

- Asthma
- Atopic dermatitis
- Other diagnosis: _____ ICD-10 Code(s): _____

For asthma, answer the following:

- Is there documentation Dupixent is prescribed by or in consultation with a pulmonologist or asthma/immunology specialist? Yes No
- Is there documentation the patient has moderate to severe asthma with an eosinophilic phenotype defined as blood eosinophil levels of at least 150 cells/mcL at baseline or at least 300 cells/mcL within the past 12 months? Yes No
- Is there documentation the patient has moderate to severe oral corticosteroid-dependent asthma? Yes No
- Select if there is documentation the patient will be using Dupixent in addition to the following:
 - Medium to high dose inhaled corticosteroid (e.g., greater than or equal to 500 mcg fluticasone propionate equivalent/day)
 - One additional controller medication

For atopic dermatitis, answer the following:

- Does the patient have moderate to severe atopic dermatitis? Yes No
- Is Dupixent prescribed by a dermatologist, allergist, or immunologist? Yes No
- Has the patient had an inadequate response or inability to tolerate medium potency or higher topical steroids? Yes No
- Has the patient had an inadequate response or inability to tolerate topical tacrolimus? Yes No

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

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

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. The information in this document is for the sole use of Future Scripts. 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.

Office use only: Dupixent_FS_2019Jun-W