FUTURE SCRIPTS

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? ❑ **Yes** ❑ **No**	Directions for Use:	
❑ 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.