mercy care

Fax completed prior authorization request form to 800-854-7614 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.mercycareaz.org/providers/completecare-forproviders/pharmacy

Dupixent
Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification to support diagnosis

Member Information			
Member Name (first & last):	Date of Birth:	Gender: ☐ Male ☐ Female	Height:
Member ID:	City:	State:	Weight:

Prescribing Provider Information			
Provider Name (first & last):	Specialty:	NPI#	DEA#
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone	Office Fax:	

Dispensing Pharmacy Information		
Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information				
Medication request is NOT for an FDA approved, or compendia-supported diagnosis (circle one): ☐ Yes ☐ No	Diagnosis:	ICD-10 Code:		
Are there any contraindications to formulary medications? If yes, please specify:	☐ Yes ☐ No	☐ New request	☐ Continuation of therapy request	
Directions for Use:	Strength:	Dosage Form:		
	Quantity:	Day Supply:	Duration of Therapy/Use:	
What medication(s) has the member tried and failed for this diagnosis? Please specify below.				

Turn-Around Time for Review	
☐ Standard – (24 hours)	☐ **Urgent** – waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____

Clinical Information					
☐ **Moderate to Severe Atopic Dermatitis**					
Were lab results using Patient-Oriented Eczema Measure (POEM) score at ≥ 8?	☐ Yes	☐ No	Were lab results of Investigator's Global Assessment (IGA) score at ≥ 3?	☐ Yes	☐ No
Was there inadequate response OR intolerable side effect with TWO preferred - medium to very high potency - topical corticosteroids?	☐ Yes	☐ No	Was there inadequate response OR intolerable side effect with ONE preferred low potency topical corticosteroid, for sensitive areas, such as face?	☐ Yes	☐ No
Was there inadequate response OR intolerable side effect to tacrolimus?	☐ Yes	☐ No	Was there inadequate response or intolerable side effect to ONE oral systemic therapy such as methotrexate OR cyclosporine OR azathioprine OR mycophenolate?	☐ Yes	☐ No
☐ **Renewal Requests ONLY**					
Did member have a response to therapy, for example, reduction in lesions?	☐ Yes	☐ No	Was the score for Patient-Oriented Eczema Measure (POEM) 0 to 2 (clear or almost clear)?	☐ Yes	☐ No
Was the Investigator's Global Assessment (IGA) score 0 or 1 (clear or almost clear)?				☐ Yes	☐ No
☐ **Moderate to Severe Asthma**					

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Was the eosinophilic phenotype, with pretreatment eosinophil count ≥150/microL?	☐ Yes	☐ No	Does member have corticosteroid dependent asthma (≥5 mg of oral prednisone or equivalent per day)?	☐ Yes	☐ No
Will Dupixent be used as ADD ON therapy to a medium or high dose ICS plus ONE additional controller such as LABA OR LAMA?	☐ Yes	☐ No	Was there compliance with the medium to high dose ICS plus ONE LABA OR LAMA OR another controller for at least THREE months AND member remained symptomatic?	☐ Yes	☐ No
Is there daily use of rescue medications such as SABA?	☐ Yes	☐ No	Are nighttime symptoms occurring one OR more times per week?	☐ Yes	☐ No
Were there a minimum of TWO exacerbations in the last 12 months requiring additional medical treatment (For example, systemic corticosteroids, ER visits, or hospitalization)?	☐ Yes	☐ No	Is the FEV1< 80% predicted?	☐ Yes	☐ No
Will Dupixent be used with another monoclonal antibody?				☐ Yes	☐ No
☐ **Renewal Request ONLY**					
Was there a response to therapy such as decrease in exacerbations OR decrease in dose of oral steroids OR improvement in FEV1 from baseline)?				☐ Yes	☐ No
Will Dupixent continued to be used as add on therapy to another asthma medication?	☐ Yes	☐ No	Will Dupixent be used with another monoclonal antibody?	☐ Yes	☐ No
☐ **Chronic Rhinosinusitis with Nasal Polyposis**					
Will Dupixent be used as add-on therapy to intranasal corticosteroids?				☐ Yes	☐ No
Have symptoms persisted for at least 12 weeks and TWO out of FOUR hallmark signs AND symptoms are present? (if yes, check that apply): ☐ Yes ☐ No			☐ Mucopurulent drainage ☐ Nasal obstruction ☐ Decreased sense of smell ☐ Facial pain, pressure, and/or fullness		
Has prescriber confirmed mucosal inflammation is present?	☐ Yes	☐ No	Was condition inadequately controlled by systemic corticosteroids AND/OR sinus surgery following intranasal corticosteroids?	☐ Yes	☐ No
☐ **Renewal Request ONLY**					
Was there response to therapy?	☐ Yes	☐ No	Was there decrease in bilateral endoscopic nasal polyps score from baseline?	☐ Yes	☐ No
Was there a decrease in the nasal congestion / obstruction score from baseline?	☐ Yes	☐ No	Will Dupixent continue to be used as add on therapy to intranasal corticosteroids?	☐ Yes	☐ No
Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records.					

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ **Date:** _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required

Standard turnaround time is 24 hours. You can call 800-624-3879 to check the status of a request.

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