



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/chp-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:		Height:	
		<input type="checkbox"/> Male	<input type="checkbox"/> Female		
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:		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> New request	<input type="checkbox"/> 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					
<input type="checkbox"/> Standard – (24 hours)		<input type="checkbox"/> 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					
<input type="checkbox"/> Moderate to Severe Atopic Dermatitis					
Were lab results using Patient-Oriented Eczema Measure (POEM) score at ≥ 8?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Were lab results of Investigator’s Global Assessment (IGA) score at ≥ 3?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was there inadequate response OR intolerable side effect with TWO preferred - medium to very high potency - topical corticosteroids?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was there inadequate response OR intolerable side effect with ONE preferred low potency topical corticosteroid, for sensitive areas, such as face?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was there inadequate response OR intolerable side effect to tacrolimus?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was there inadequate response or intolerable side effect to ONE oral systemic therapy such as methotrexate OR cyclosporine OR azathioprine OR mycophenolate?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Renewal Requests ONLY					
Did member have a response to therapy, for example, reduction in lesions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was the score for Patient-Oriented Eczema Measure (POEM) 0 to 2 (clear or almost clear)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was the Investigator’s Global Assessment (IGA) score 0 or 1 (clear or almost clear)?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Moderate to Severe Asthma					

Was the eosinophilic phenotype, with pretreatment eosinophil count $\geq 150/\mu\text{mL}$?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does member have corticosteroid dependent asthma (≥ 5 mg of oral prednisone or equivalent per day)?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is there daily use of rescue medications such as SABA?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are nighttime symptoms occurring one OR more times per week?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is the FEV1 < 80% predicted?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Will Dupixent be used with another monoclonal antibody?				<input type="checkbox"/> Yes	<input type="checkbox"/> 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)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Will Dupixent continued to be used as add on therapy to another asthma medication?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Will Dupixent be used with another monoclonal antibody?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Chronic Rhinosinusitis with Nasal Polyposis

Will Dupixent be used as add-on therapy to intranasal corticosteroids?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Have symptoms persisted for at least 12 weeks and TWO out of FOUR hallmark signs AND symptoms are present? (if yes, check that apply):	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Mucopurulent drainage <input type="checkbox"/> Nasal obstruction <input type="checkbox"/> Decreased sense of smell <input type="checkbox"/> Facial pain, pressure, and/or fullness
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Has prescriber confirmed mucosal inflammation is present?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was condition inadequately controlled by systemic corticosteroids AND/OR sinus surgery following intranasal corticosteroids?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Renewal Request ONLY

Was there response to therapy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was there decrease in bilateral endoscopic nasal polyps score from baseline?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Was there a decrease in the nasal congestion / obstruction score from baseline?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Will Dupixent continue to be used as add on therapy to intranasal corticosteroids?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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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 833-711-0776 to check the status of a request.