

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)			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:
<input type="checkbox"/> Check if requesting brand			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information (required)					
Select the diagnosis below: <input type="checkbox"/> Moderate to severe chronic atopic dermatitis <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Clinical Information: Select if Dupixent is prescribed by or in consultation with one of the following specialists: <input type="checkbox"/> Dermatologist <input type="checkbox"/> Allergist/immunologist Does the patient have history of failure, contraindication, or intolerance to one medium to high potency topical corticosteroid? <input type="checkbox"/> Yes <input type="checkbox"/> No Select if the patient has history of failure or intolerance to the following, unless the patient is not a candidate for therapy (e.g., immunocompromised): <input type="checkbox"/> Elidel (pimecrolimus) topical cream <input type="checkbox"/> Tacrolimus topical ointment					
Reauthorization: If this is a reauthorization request, answer the following question: Is there documentation the patient has had a positive clinical response to Dupixent therapy (e.g., reduction in body surface area involvement, reduction in pruritus severity)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Quantity Limit Requests: What is the quantity requested per MONTH? _____ What is the reason for exceeding the plan limitations? <input type="checkbox"/> Titration or loading dose purposes <input type="checkbox"/> Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime) <input type="checkbox"/> Requested strength/dose is not commercially available <input type="checkbox"/> Other: _____					

Please note that this form is to be completed by the prescribing physician. 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. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). 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_Comm_2017Dec

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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:

ProCare PBM 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.