



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/pharmacy.html](http://www.mercycareaz.org/providers/pharmacy.html)

# 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"/> <b>Urgent</b> – 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"/> <b>Atopic Dermatitis</b>				
Is the diagnosis MODERATE to SEVERE chronic atopic dermatitis?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
There is a history of T/F, C/I, or intolerance to the following:	<input type="checkbox"/> One topical calcineurin inhibitor (Elidel or Protopic) <input type="checkbox"/> Eucrisa <input type="checkbox"/> Adbry <input type="checkbox"/> Opzelura			
There is a history of failure, C/I, or intolerance to the following:	<input type="checkbox"/> One topical calcineurin inhibitor (Elidel or Protopic) <input type="checkbox"/> Eucrisa <input type="checkbox"/> One topical corticosteroid (mometasone furoate, flucinolone acetone (generic Synalar), flucinolone)			
Is Dupixent being given w/COMBO such as Xolair, Rituxan, Enbrel, OR Remicade / Inflectra?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> <b>Renewal Request ONLY</b>				
Is there documentation of positive clinical response to therapy?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
There is a history of T/F, C/I, or intolerance to the following:	<input type="checkbox"/> One topical calcineurin inhibitor (Elidel or Protopic) <input type="checkbox"/> Eucrisa <input type="checkbox"/> Adbry <input type="checkbox"/> Opzelura			

There is a history of failure, C/I, or intolerance to the following:		<input type="checkbox"/> One topical calcineurin inhibitor (Elidel or Protopic) <input type="checkbox"/> Eucrisa <input type="checkbox"/> One topical corticosteroid (mometasone furoate, flucinolone acetonide (generic Synalar), flucinonide)				
Is Dupixent being given w/COMBO such as Xolair, Rituxan, Enbrel, OR Remicade/Inflectra?					<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> <b>Asthma</b>						
Is there documentation confirming diagnosis of MODERATE to SEVERE asthma?					<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma is uncontrolled by at least ONE of the following:	<input type="checkbox"/> Poor symptom control ACQ score >1.5 OR ACT score <20	<input type="checkbox"/> ≥2 bursts of systemic steroids for at least 3 days each in the previous year	<input type="checkbox"/> Asthma-related emergency treatment (ER visit, hospital admission, OR unscheduled physician's office visit for nebulizer or other urgent treatment)			
	<input type="checkbox"/> Patient is currently dependent on oral corticosteroids for the treatment of asthma		<input type="checkbox"/> Airflow limitation (after appropriate bronchodilator withhold FEV1 <80% predicted [in face of reduced FEV1 / FVC defined as < lower limit of normal])			
Used in COMBO with ONE of the following:	ONE high-dose COMBO ICS/LABA <input type="checkbox"/> Advair/AirDuo Resplick <input type="checkbox"/> Symbicort <input type="checkbox"/> Breo Ellipta		COMBO therapy includes BOTH of the following:		ONE high-dose ICS product: <input type="checkbox"/> Alvesco <input type="checkbox"/> Asmanex <input type="checkbox"/> QVAR	
					ONE additional asthma controller <input type="checkbox"/> LABA - Striverdi or Arcapta <input type="checkbox"/> Singulair <input type="checkbox"/> theophylline	
Is there documentation that asthma is an eosinophilic phenotype as defined by a baseline peripheral blood eosinophil level ≥150 cells/mL within the past 6 weeks?					<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is there currently a dependency on oral steroids for asthma?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is the member currently on Dupixent?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Is Dupixent being received in COMBO with ONE of the following?		Anti-interleukin-5 therapy: <input type="checkbox"/> Nucala <input type="checkbox"/> Cinqair <input type="checkbox"/> Fasenra <input type="checkbox"/> N/A		Anti-IgE therapy: <input type="checkbox"/> Xolair <input type="checkbox"/> N/A		
<input type="checkbox"/> <b>Renewal Request ONLY</b>						
Documentation of positive clinical response to therapy with at least ONE of the following:		<input type="checkbox"/> Reduction in frequency of exacerbations	<input type="checkbox"/> Decreased use of rescue medications	<input type="checkbox"/> Increased % predicted FEV1 from baseline	<input type="checkbox"/> Reduction in severity / frequency of symptoms	<input type="checkbox"/> Reduction in oral steroid requirements
Is Dupixent being received in COMBO with ONE of the following?		Anti-interleukin-5 therapy: <input type="checkbox"/> Nucala <input type="checkbox"/> Cinqair <input type="checkbox"/> Fasenra <input type="checkbox"/> N/A		Anti-IgE therapy: <input type="checkbox"/> Xolair <input type="checkbox"/> N/A		
Is Dupixent being used in COMBO with an ICS-containing controller medication?					<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> <b>Chronic Rhinosinusitis with Nasal Polyposis</b>						
Is there documentation confirming diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP)?					<input type="checkbox"/> Yes	<input type="checkbox"/> No
Which TWO or more of the following symptoms have been present ≥12 weeks?		<input type="checkbox"/> Mucopurulent discharge	<input type="checkbox"/> Nasal obstruction and congestion	<input type="checkbox"/> Decreased or absent sense of smell	<input type="checkbox"/> Facial pressure or pain	
Is there evidence with ONE of the following?		<input type="checkbox"/> Inflammation on paranasal sinus exam OR computed tomography		<input type="checkbox"/> Purulence coming from paranasal sinuses OR osteomata complex		
Is there presence of nasal polyps?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Member meets ONE of the following:		<input type="checkbox"/> Prior sino-nasal surgery <input type="checkbox"/> Systemic steroids in previous 2 years
Is Dupixent being received in COMBO with ONE of the following?	Anti-interleukin-5 therapy: <input type="checkbox"/> Nucala <input type="checkbox"/> Cinqair <input type="checkbox"/> Fasenra <input type="checkbox"/> N/A		Anti-IgE therapy: <input type="checkbox"/> Xolair <input type="checkbox"/> N/A		Was there symptom relief after trial of ALL of the following:	
					<input type="checkbox"/> Nasal saline irrigation <input type="checkbox"/> N/A	Antileukotriene agents: <input type="checkbox"/> Montelukast <input type="checkbox"/> Zafirlukast <input type="checkbox"/> Zileuton <input type="checkbox"/> N/A
				Intranasal steroids: <input type="checkbox"/> fluticasone <input type="checkbox"/> mometasone <input type="checkbox"/> triamcinolone <input type="checkbox"/> N/A		
Is the member currently on Dupixent therapy?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Will Dupixent be given as an add-on maintenance therapy in COMBO with intranasal corticosteroids?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> <b>Renewal Request ONLY</b>						
Is there documentation confirming positive clinical response to therapy?		<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
Is Dupixent being received in COMBO with ONE of the following?		Anti-interleukin-5 therapy <input type="checkbox"/> Nucala		Anti-IgE therapy <input type="checkbox"/> Xolair		

- Cinqair
- Fasenra
- N/A

<b><input type="checkbox"/> Eosinophilic Esophagitis (EoE)</b>			
Is there documentation confirming a diagnosis of eosinophilic esophagitis (EoE)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the member have symptoms of esophageal dysfunction?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is there documentation confirming the member has at least 15 intraepithelial eosinophils per high power field (HPF)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have other causes of esophageal eosinophilia been excluded?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Documentation confirming T/F, C/I, or intolerance to at least an 8-week trial of ONE of the following:	<input type="checkbox"/> Proton pump inhibitors (for example, pantoprazole, omeprazole),	<input type="checkbox"/> Topical (esophageal) corticosteroids (for example, budesonide, fluticasone)	
<b><input type="checkbox"/> Renewal Request ONLY</b>			
Documentation confirming positive clinical response to therapy as evidenced by improvement of at least ONE of the following from baseline:	<input type="checkbox"/> Symptoms (dysphagia, food impaction, heartburn, chest pain),	<input type="checkbox"/> Histologic measures (esophageal intraepithelial eosinophil count)	<input type="checkbox"/> Endoscopic measures (edema, furrows, exudates, rings, strictures)
<b><input type="checkbox"/> Prurigo Nodularis (PN)</b>			
Is there documentation confirming a diagnosis of Prurigo Nodularis (PN)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the member have at least 20 nodular lesions?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is there documentation confirming T/F, C/I, or intolerance to ONE previous PN treatment (topical corticosteroids, topical calcineurin inhibitors, [pimecrolimus, tacrolimus], topical capsaicin)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dupixent was prescribed by ONE of the following specialists:	<input type="checkbox"/> Dermatologist	<input type="checkbox"/> Allergist	<input type="checkbox"/> Immunologist <input type="checkbox"/> N/A
<b><input type="checkbox"/> Renewal Request ONLY</b>			
Documentation confirming positive clinical response to therapy as evidenced by improvement of at least ONE of the following:	<input type="checkbox"/> Reduction of nodular lesions from baseline	<input type="checkbox"/> Improvement in symptoms (pruritis, inflammation) from baseline	
Dupixent was prescribed by ONE of the following specialists:	<input type="checkbox"/> Dermatologist	<input type="checkbox"/> Allergist	<input type="checkbox"/> Immunologist <input type="checkbox"/> N/A
<b>Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records</b>			

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