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					
☐ **Atopic Dermatitis**					
Is the diagnosis MODERATE to SEVERE chronic atopic dermatitis?				☐ Yes	☐ No
There is a history of T/F, C/I, or intolerance to the following:	☐ One topical calcineurin inhibitor (Elidel or Protopic)		☐ Eucrisa		
☐ Is the diagnosis chronic atopic dermatitis AND determined SEVERE based on physician assessment?				☐ Yes	☐ No
There is a history of failure, C/I, or intolerance to BOTH of the following:	One topical calcineurin inhibitor: ☐ Elidel ☐ Protopic				
☐ Is the member currently on Dupixent therapy?	☐ Yes	☐ No	☐ Is Dupixent being given w/COMBO such as Xolair, Rituxan, Enbrel, OR Remicade / Inflectra	☐ Yes	☐ No
☐ **Renewal Request ONLY**					
Is there documentation of positive clinical response to therapy?	☐ Yes	☐ No	☐ Is Dupixent being given w/COMBO such as Xolair, Rituxan, Enbrel, OR Remicade/Inflectra?	☐ Yes	☐ No
☐ **Asthma**					
Is there documentation confirming diagnosis of MODERATE to SEVERE asthma?				☐ Yes	☐ No

Asthma is uncontrolled by at least ONE of the following:	☐ Poor symptom control ACQ score >1.5 OR ACT score <20	☐ ≥2 bursts of systemic steroids for at least 3 days each in the previous year	☐ Asthma-related emergency treatment (ER visit, hospital admission, OR unscheduled physician's office visit for nebulizer or other urgent treatment)
	☐ Patient is currently dependent on oral corticosteroids for the treatment of asthma	☐ 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 ☐ Advair/AirDuo Respiclick ☐ Symbicort ☐ Breo Ellipta	COMBO therapy includes BOTH of the following:	ONE high-dose ICS product: ☐ Alvesco ☐ Asmanex ☐ QVAR ONE additional asthma controller ☐ LABA - Striverdi or Arcapta ☐ Singulair ☐ 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?	☐ Yes	☐ No

Is there currently a dependency on oral steroids for asthma?	☐ Yes	☐ No	Is the member currently on Dupixent?	☐ Yes	☐ No

Is Dupixent being received in COMBO with ONE of the following?	Anti-interleukin-5 therapy: ☐ Nucala ☐ Cinqair ☐ Fasenra ☐ N/A	Anti-IgE therapy: ☐ Xolair ☐ N/A

☐ Renewal Request ONLY

Documentation of positive clinical response to therapy with at least ONE of the following:	☐ Reduction in frequency of exacerbations	☐ Decreased use of rescue medications	☐ Increased % predicted FEV1 from baseline	☐ Reduction in severity / frequency of symptoms	☐ Reduction in oral steroid requirements

Is Dupixent being received in COMBO with ONE of the following?	Anti-interleukin-5 therapy: ☐ Nucala ☐ Cinqair ☐ Fasenra ☐ N/A	Anti-IgE therapy: ☐ Xolair ☐ N/A

Is Dupixent being used in COMBO with an ICS-containing controller medication?	☐ Yes	☐ No

☐ Chronic Rhinosinusitis with Nasal Polyposis

Is there documentation confirming diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP)?	☐ Yes	☐ No

Which TWO or more of the following symptoms have been present ≥12 weeks?	☐ Mucopurulent discharge	☐ Nasal obstruction and congestion	☐ Decreased or absent sense of smell	☐ Facial pressure or pain

Is there evidence with ONE of the following?	☐ Inflammation on paranasal sinus exam OR computed tomography	☐ Purulence coming from paranasal sinuses OR osteomata complex

Is there presence of nasal polyps?	☐ Yes	☐ No	Member meets ONE of the following:	☐ Prior sino-nasal surgery	☐ Systemic steroids in previous 2 years

Is Dupixent being received in COMBO with ONE of the following?	Anti-interleukin-5 therapy: ☐ Nucala ☐ Cinqair ☐ Fasenra ☐ N/A	Anti-IgE therapy: ☐ Xolair ☐ N/A	Was there symptom relief after trial of ALL of the following:	☐ Nasal saline irrigation ☐ N/A	Antileukotriene agents: ☐ Montelukast ☐ Zafirlukast ☐ Zileuton ☐ N/A	Intranasal steroids: ☐ fluticasone ☐ mometasone ☐ triamcinolone ☐ N/A

Is the member currently on Dupixent therapy?	☐ Yes	☐ No	Will Dupixent be given as an add-on maintenance therapy in COMBO with intranasal corticosteroids?	☐ Yes	☐ No

☐ Renewal Request ONLY

Is there documentation confirming positive clinical response to therapy?	☐ Yes	☐ No	Will Dupixent continue to be used as add on therapy to intranasal corticosteroids?	☐ Yes	☐ No

Is Dupixent being received in COMBO with ONE of the following?	Anti-interleukin-5 therapy ☐ Nucala ☐ Cinqair ☐ Fasenra ☐ N/A	Anti-IgE therapy ☐ Xolair ☐ N/A

☐ Eosinophilic Esophagitis (EoE)

Is there documentation confirming a diagnosis of eosinophilic esophagitis (EoE)?	☐ Yes	☐ No
Does the member have symptoms of esophageal dysfunction?	☐ Yes	☐ No

Is there documentation confirming the member has at least 15 intraepithelial eosinophils per high power field (HPF)?			☐ Yes	☐ No
Have other causes of esophageal eosinophilia been excluded?			☐ Yes	☐ No
Documentation confirming T/F, C/I, or intolerance to at least an 8-week trial of ONE of the following:	☐ Proton pump inhibitors (for example, pantoprazole, omeprazole),	☐ Topical (esophageal) corticosteroids (for example, budesonide, fluticasone)		
☐ **Renewal Request ONLY**				
Documentation confirming positive clinical response to therapy as evidenced by improvement of at least ONE of the following from baseline:	☐ Symptoms (dysphagia, food impaction, heartburn, chest pain),	☐ Histologic measures (esophageal intraepithelial eosinophil count)	☐ Endoscopic measures (edema, furrows, exudates, rings, strictures)	
☐ **Prurigo Nodularis (PN)**				
Is there documentation confirming a diagnosis of Prurigo Nodularis (PN)?			☐ Yes	☐ No
Does the member have at least 20 nodular lesions?			☐ Yes	☐ 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)?			☐ Yes	☐ No

Dupixent was prescribed by ONE of the following specialists:	☐ Dermatologist	☐ Allergist	☐ Immunologist	☐ N/A
☐ **Renewal Request ONLY**				
Documentation confirming positive clinical response to therapy as evidenced by improvement of at least ONE of the following:	☐ Reduction of nodular lesions from baseline		☐ Improvement in symptoms (pruritis, inflammation) from baseline	
Dupixent was prescribed by ONE of the following specialists:	☐ Dermatologist	☐ Allergist	☐ Immunologist	☐ N/A

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.