



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"/> Atopic Dermatitis					
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 medium to very-high potency topical corticosteroid (Elocon, Synalar Lidex)	<input type="checkbox"/> One topical calcineurin inhibitor (Elidel or Protopic)	<input type="checkbox"/> Eucrisa		
<input type="checkbox"/> Is the diagnosis chronic atopic dermatitis AND determined SEVERE based on physician assessment?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
There is a history of failure, C/I, or intolerance to BOTH of the following:	ONE Medium to very-high potency topical corticosteroid: <input type="checkbox"/> Elocon <input type="checkbox"/> Synalar <input type="checkbox"/> Lidex		One topical calcineurin inhibitor: <input type="checkbox"/> Elidel <input type="checkbox"/> Protopic		
<input type="checkbox"/> Is the member currently on Dupixent therapy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Is Dupixent being given w/COMBO such as Xolair, Rituxan, Enbrel, OR Remicade / Inflectra	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Renewal Request ONLY					
<input type="checkbox"/> Is there documentation of positive clinical response to therapy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> 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"/> Asthma					

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 Respiclick <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"/> Renewal Request ONLY						
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"/> Chronic Rhinosinusitis with Nasal Polyposis						
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"/> Renewal Request ONLY						
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 <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"/> Eosinophilic Esophagitis (EoE)						
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)	
<input type="checkbox"/> Renewal Request ONLY			
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)
<input type="checkbox"/> Prurigo Nodularis (PN)			
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
<input type="checkbox"/> Renewal Request ONLY			
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
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.