

Fax completed prior authorization request form to 855-247-3677 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/rbha-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

Date of E	Birth:				Gen			Heig	ht:			
		_					Female					
City:				Stat	ie:			Weight:				
Specialty	r:		NPI#				DEA#					
City:				State:			Zip C	íp Code:				
Office Contact:					Office Fax:							
						1						
Pharmacy Name:				Pharmacy Phone: Pharmacy Fa					IX:			
		<u> </u>										
Medication request is NOT for an FDA approved, or compendia-supported diagnosis (circle one): Yes No					ICD-10 Code:							
Are there any contraindications to formulary medications? If yes, please specify:					□ No		□ New □ Continuation request therapy red					
Directions for Use: Stre						Dosag	e Form	1:				
		-										
Qu					Day Supply:			Duration of Therapy/Use:				
ailed for this	s diac	nosis? Ple	ease sp	ecifv belo	w.							
	2	,		,								
or ability to regain maximum function, you can ask for an expe											lth,	
`	<u> </u>											
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)									Eucris	sa		
ND determ	ined :	•	,	n physicia	n assessm	ent?			Yes		No	
Elidel		ineurin inhi	bitor:									
				ls Dupixe	nt beina aiv	/en w/CC	MBO		Yes		No	
□ Is the member currently on Dupixent therapy? □ Yes					olair, Ritux	an, Enbr				_		
			1	-				1				
🗆 No							olair,		Yes		No	
I	L							I				
Asthma Is there documentation confirming diagnosis of MODERATE to SEVERE asthma?									Yes		No	
	City: Specialty City: City: approved, dications? dicati	Specialty: City: City: approved, or dications? Stre Qua ailed for this diag Qua ailed for this diag Au Au Au Au Au Au Au Au Au Au	City: Specialty: City: Office Pr Pharmac approved, or Diagnosis dications? Quantity: ailed for this diagnosis? Ple Quantity: ailed for this diagnosis? Ple Image: Construct of the strength of the strengt	City: Specialty: City: Office Phone Pharmacy Phor approved, or Diagnosis: dications? dications? Quantity: ailed for this diagnosis? Please sp Graphic dermatitis? ic atopic dermatitis? ic atopic dermatitis? Diagnosis: Diagnosis: Outrgent – waiting 24 hours or ability to regain maximus Signature: One topical calcineurin inhibitor: protopic ND determined SEVERE based or One topical calcineurin inhibitor: Elidel Protopic py? Yes No Is Dupixent being Rituxan, Enbrel,	City: Image: City: State Specialty: NPI# City: State: Office Phone Pharmacy Phone: approved, or Diagnosis: dications? Image: Present Strength: Quantity: Day Sup ailed for this diagnosis? Please specify belo Image: I	City: Image: State: Specialty: NPI# City: State: Office Phone Pharmacy Phone: approved, or Diagnosis: dications? Image: Yes Quantity: Day Supply: ailed for this diagnosis? Please specify below. Image: Protopic or ability to regain maximum function, you can signature: Image: Protopic or ability to regain maximum function, you can signature: Image: Protopic or ability to regain maximum function, you can signature: Image: Protopic or ability to regain maximum function, you can signature: Image: Protopic or ability to regain maximum function, you can signature: Image: Protopic or ability to regain maximum function, you can signature: Image: Protopic or ability to regain maximum function, you can signature: Image: Protopic or ability to regain maximum function, you can signature: Image: Protopic or ability to regain maximum function, you can signature: Image: Protopic or ability to regain maximum function, you can signature: Image: Protopic or ability to regain maximum function, you can signature: Image: Protopic or ability to regain maximum function, you can signature: Image: Protopic or ability to regain maximum function, you can signature: Image: Protopic or ability to regain maximum function, you can signature: Image: Protopic or ability to regain thit wor abil	Image: State: Male Fer City: State: State: City: State: Office Phone Office Image: Office Phone Office Phone: Pharmacy Phone: Pharmacy Pharmacy Phone: Pharmacy Pharmacy Pharmacy approved, or Diagnosis: ICD-10 dications? Image: Present Pharmacy No No Quantity: Day Supply: Duratice Quantity: Day Supply: Duratice ailed for this diagnosis? Please specify below. Image: Present Pharmacy Image: Present Pharmacy One topical calcineurin inhibitor (Elidel or Protopic) Protopic Image: Protopic One topical calcineurin inhibitor: Image: Protopic Image: Protopic No Is Dupixent being given w/COMBO such as Xolair, Rituxan, Enbro OR Remicade / Inflectra	Image: City: Image: City: State: Image: City: State: Image: City: City: City: City: City: City: State: City: C	City: Image Female Specially: NPI# DEA# City: State: Zip Code: Office Phone Office Fax: Zip Code: Pharmacy Phone: Pharmacy Fax: approved, or Diagnosis: ICD-10 Code: dications? Yes No New Quantity: Day Supply: Duration of Therap ailed for this diagnosis? Please specify below. Duration of Therap ic atopic dermatitis? Image: Image: ic atopic dermatitis? Image: Image: One topical calcineurin inhibitor (Elidel or Protopic) Protopic Image: ND One topical calcineurin inhibitor (Elidel or Protopic) Image: Image: One topical calcineurin inhibitor: Image: Image: Image: Im	Image Image Female City: State: Weight: Specialty: NPI# DEA# City: State: Zip Code: Office Phone Office Fax: ICD-10 Code: approved, or Diagnosis: ICD-10 Code: dications? Image Yes No New Guantity: Day Supply: Duration of Therapy/Use: Duration of Therapy/Use: ailed for this diagnosis? Please specify below. Image: Yes Image: Imag	City: Male Female Specialty: NPI# DEA# City: State: Zip Code: Office Phone Office Fax: Pharmacy Phone: Pharmacy Fax: approved, or Diagnosis: ICD-10 Code: dications? Yes No New Continuation therapy request Strength: Day Supply: Duration of Therapy/Use: ailed for this diagnosis? Please specify below. Quantity: Day Supply: Duration of Therapy/Use: ailed for this diagnosis? Please specify below. Icatopic dermatitis? Yes Yes Yes Yes ic atopic dermatitis? One topical calcineurin inhibitor (Elidel or Protopic) Yes Yes One topical calcineurin inhibitor (Elidel or Protopic) Yes One topical calcineurin inhibitor: Elidel Protopic No Is Dupixent being given w/COMBO Yes OR Remicade / Inflectra No Is Dupixent being given w/COMBO such as Xolair, Rituxan, Enbrel, OR Remicade / Inflectra? Yes Core	

	Poor symptom control				≥2 bursts of systemic				ö ,								
uncontrolled by at	ACQ score >1.5 OR ACT			steroids for at least 3 days			s	(ER visit, hospital admission, OR									
least ONE of the	score <20				each in the previous year				unscheduled physician's office visit fo								
following:									nebulizer or other urgent treatment)								
	Patient is currently dependent on								itation (after appropriate bronchodilator								
	corticosteroids for the treatment				ment o	of asthma	l			<80% predicted [in							
	FEV						FEV1		VC defined as < lower limit of normal)								
									10	ONE high-dose ICS product:							
										□ Alvesco							
Used in COMBO with				1BO ICS/LA	BA	COMBO therapy includes			.c	□ Asmanex							
ONE of the following:		Advair/A		espiclick		BOTH of the following:				QVAR							
		Symbico				_ • • • • • • • • • • • • • • • • • • •			_	ONE additional asthma controller							
		Breo Ellij	Jia							LABA - Striverdi or Arcapta							
										Singulair theophylline							
Is there documentation	that a	ethma is r	n oosir	onhilic nhe	notvo	o as defin	od by a k	acolino		theophylline heral blood				No			
eosinophil level ≥150 ce					потур		leu by a i	Jaseime	penpher			res		NO			
Is there currently a depe			-			Yes I	🗆 No	ls the m	ember (currently on		Yes		No			
asthma?	Shuci		3161010	13 101		163 1		Dupixer		Surrently on		163		NO			
Is Dupixent being receiv	/ed in	COMBO	with ON	IF of the	Anti	-interleuki	in-5 thera			Anti-IgE therapy:							
following?		0011120				Nucala		PJ.		□ Xolair							
g.						Cinqair				\square N/A							
						Fasenra											
						N/A											
Renewal Request	ONL	Y															
Documentation of positi	ve	🗆 Redu	ction in		Decrea	ased		eased %		Reduction in		Reduct	tion ir	n oral			
clinical response to	ve		ency of			rescue		dicted FE		severity /		steroid		i orar			
therapy with at least ON	IE		erbatior		nedica	ations		n baselin		frequency of		require	ment	s			
of the following:										symptoms							
Is Dupixent being receiv	/ed in	COMBO	with ON	IE of the		-interleuki	in-5 thera	ру:		Anti-IgE therapy:							
following?										□ Xolair							
									D N/A								
					Fasenra N/A												
						-						Vec		No			
Is Dupixent being used in COMBO with an ICS-containing controller medication?									NO								
		Chronic Rhinosinusitis with Nasal Polyposis															
		s with Nas															
Chronic Rhinosin	usitis		-	•	inosin	usitis with	nasal po	olvposis (CRSwN	P)?		Yes		No			
Chronic Rhinosin Is there documentation	usitis confir	rming diag	-	•	inosin	usitis with	n nasal po	olyposis (CRSwN	P)?		Yes		No			
Chronic Rhinosin Is there documentation Which TWO or more of	usitis confir the fo	rming diag	-	f chronic rhi I Mucopu	rulent	D N	lasal obst	ruction	D De	ecreased or absent		Facia	l pres				
Chronic Rhinosin Is there documentation	usitis confir the fo	rming diag	nosis o	f chronic rh	rulent	D N		ruction	D De	ecreased or absent nse of smell		Facia or pai	l pres n				
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Is there documentation confirming the member (HPF)?	has at least 15	intraepithelial	eosinophil	s per hi	igh power	field		Yes		ЛС	١o
Have other causes of esophageal eosinophilia been excluded?								N C	١o		
Documentation confirming T/F, C/I, or intolerance to at least an 8-week trial of ONE of the following:	ump inhibitors (for example, Dizole, omeprazole),						phageal) corticosteroids , 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:	ns I Histologic measures gia, food (esophageal n, heartburn, intraepithelial eosinophil count)				s	 Endoscopic measures (edema, furrows, exudates, rings, strictures) 					
Prurigo Nodularis (PN)											
Is there documentation confirming a diagnosis of	of Prurigo Nodu	ılaris (PN)?							/es		No
Does the member have at least 20 nodular lesion	ons?								/es		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)?											
Dupixent was prescribed by ONE of the followir	ng specialists:	Derma	tologist		llergist		Immunol	ogist		N/A	
Renewal Request ONLY		1									
Documentation confirming positive clinical resp therapy as evidenced by improvement of at leas following:			tion of nod aseline	ular lesi	ions		Improver (pruritis, i baseline				
Dupixent was prescribed by ONE of the followir	ng specialists:	Derma	tologist		llergist		Immunol	ogist		N/A	
Additional information the prescribing provi	der feels is im	portant to thi	s review.	Please	specify	below	v or subn	nit med	ical ı	reco	rds
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 tru	ie and accura	te and ref	lects of	ffice note	es.					

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 800-564-5465 to check the status of a request.