

If the following information is not complete, correct, or legible, the SA process can be delayed.

Please use one form per member.

Dupixent for atopic dermatitis has an electronic edit and does not require submission of this fax form; this form is for other indications. Length of Authorization = 1 year.

MEMBER INFORMATION

Last Name:

First Name:

Medicaid ID Number:

Date of Birth:

Expected Pregnancy Term Date:

Requested Start Date:

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name:

First Name:

NPI Number:

Phone Number:

Fax Number:

DIAGNOSIS AND MEDICAL INFORMATION

For a diagnosis of chronic rhinosinusitis with nasal polyps only:

1. Is the member 12 years of age or older?
 Yes No
2. Does the member have inadequate response after 3 consistent months' use of preferred intranasal steroids or oral corticosteroids?
 Yes No
3. Is the member concurrently being treated with intranasal corticosteroids?
 Yes No
4. Has the physician assessed baseline disease severity utilizing an objective measurement/tool?
 Yes No

(Form continued on next page)

Member's Last Name:

Member's First Name:

For a diagnosis of moderate to severe asthma:

1. Is the member 6 years of age or older?
 Yes No
2. Does the member have a diagnosis of moderate to severe asthma with either:
 - Asthma with eosinophilic phenotype with eosinophil count \geq 150 cells/mcL; **OR**
 - Oral corticosteroid-dependent asthma with at least 1 month of daily oral corticosteroid use within the last 3 months Yes No

For a diagnosis of eosinophilic esophagitis (EoE):

1. Is the member 1 year of age or older?
 Yes No
2. Does the member weigh \geq 15 kg?
 Yes No
3. Is Dupixent prescribed by or in consultation with an allergist or gastroenterologist?
 Yes No
4. Has the member responded clinically to treatment with a topical glucocorticosteroid or proton pump inhibitor?
 Yes No

For adult members with inadequately controlled chronic obstructive pulmonary disease (COPD) and an eosinophilic phenotype:

1. Is the member 18 years of age or older?
 Yes No
2. Is Dupixent prescribed by or in consultation with a pulmonologist?
 Yes No
3. Does the member have a diagnosis of COPD that is inadequately controlled and a minimum blood eosinophil count of 300 cells/mcL at screening, measured within the past 12 months?
 Yes No
4. Is the member receiving maximal inhaled therapy consisting of a long-acting muscarinic antagonist (LAMA), long-acting beta agonist (LABA), and inhaled corticosteroid (ICS) (or therapy of LAMA plus LABA if ICS is contraindicated)?
 Yes No

(Form continued on next page)

Member's Last Name: Member's First Name:

For adult members with a diagnosis of prurigo nodularis (PN):

1. Is the member 18 years of age or older?
 Yes No
2. Does the member have a diagnosis of PN?
 Yes No
3. Is Dupixent prescribed by or in consultation with a dermatologist, allergist, or immunologist?
 Yes No

For members with a diagnosis of Chronic Spontaneous Urticaria:

1. Is the member 12 years of age or older?
 Yes No
2. Does the member have a diagnosis of Chronic Spontaneous Urticaria?
 Yes No
3. Has the member had a 30 day trial and failure, or intolerance to H1 antihistamine treatment?
 Yes No

For adult members with a diagnosis of Bullous Pemphigoid:

1. Is the member 18 years of age or older?
 Yes No
2. Does the member have a diagnosis of Bullous Pemphigoid?
 Yes No

For renewal:

1. Has the member experienced a therapeutic benefit from the requested medication?
 Yes No
2. Is the member free of toxicity from the requested medication?
 Yes No

Prescriber Signature (Required)

Date

By signature, the Physician confirms the above information is accurate and verifiable by patient records.

Please include ALL requested information; Incomplete forms will delay the SA process.

Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

Fax this form to 1-866-940-7328

Pharmacy PA Call Center 1-800-310-6826