South Dakota Department of Social Services

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
Mon-Sat: 7am to 7pm Central

Dupixent® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Atopic dermatitis
- ❑ Chronic rhinosinusitis with nasal polyposis (CRSwNP)
- ❑ Moderate to severe asthma
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Atopic dermatitis:

Has the patient had a documented trial of a topical corticosteroid, pimecrolimus cream, or tacrolimus ointment within the last 120 days? ❑ **Yes** ❑ **No**

Was Dupixent prescribed by or in consultation with a dermatologist or allergist/immunologist? ❑ **Yes** ❑ **No**

Chronic rhinosinusitis with nasal polyposis (CRSwNP):

Does the patient have a diagnosis of inadequately controlled CRSwNP? ❑ **Yes** ❑ **No**

Has the patient had a documented trial of an intranasal corticosteroid (INCS) within the last 120 days? ❑ **Yes** ❑ **No**

Was Dupixent prescribed by or in consultation with an allergist/immunologist, pulmonologist, or otolaryngologist (i.e., ENT)? ❑ **Yes** ❑ **No**

Moderate to severe asthma:

Has the patient had a documented trial of an inhaled corticosteroid (ICS) within the last 120 days? ❑ **Yes** ❑ **No**

Select if the patient has had a documented trial of one of the following controller medications within the last 120 days:

- ❑ Long-acting beta 2 agonist (LABA)
- ❑ LABA/ICS combination
- ❑ Long-acting muscarinic antagonists (LAMA)
- ❑ Leukotriene modifiers
- ❑ Theophylline

Was Dupixent prescribed by or in consultation with an allergist/immunologist or pulmonologist? ❑ **Yes** ❑ **No**

South Dakota Department of Social Services

Dupixent® Prior Authorization Request Form (Page 2 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-844-403-1029.