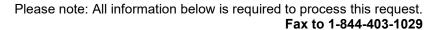


Please note: All information below is required to process this request.

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:		Specialty:	
Date of Birth:			Office Phone:			
Street Address:			Office Fax:			
City:	State:	Zip:	Office Street Address	:		
Phone:	L	1	City:	State:	Zip:	
Medication Information (required)						
Medication Name:			Strength:	/	Dosage Form:	
☐ Check if requesting brand			Directions for Use:			
☐ Check if request is	erapy					
Clinical Information (required)						
Select the diagnosis	s below:					
☐ Atopic dermatitis						
☐ Chronic rhinosinusitis with nasal polyposis (CRSwNP)						
□ Moderate to severe asthma						
☐ Eosinophilic esopl	hagitis					
□ Prurigo nodularis □ Other diagnosis: ICD-10 Code(s):						
		ICD-1	o code(s)			
Clinical information: Select if the requested medication is prescribed by or in consultation with one of the following specialists:						
□ Allergist/Immunologist □ Gastroenterologist □ Otolaryngologist □ Pulmonologist □ Other						
Will the requested medication be used in combination with another biologic agent or targeted immunomodulator? Yes No						
If requesting a citrate-free product, has the patient tried citrate product first? Yes No When:						
Atopic dermatitis:						
	a documented trial of a t lys? □ Yes □ No Lis		mecrolimus cream, tacro	olimus ointm	ent, Eurisa (crisaborole) ointment	
	itis with nasal polypos	•				
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						
Moderate to severe					-	
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						
	scarinic antagonists (LA					
☐ Leukotriene mo	difiers					
☐ Theophylline	ogitio					
Eosinophilic esopha	-	nigh-doce proton numn	inhibitor for at least 9 w	aeke or owol	llowed topical steroid (o.g.	
Has the patient had a documented trial of a high-dose proton pump inhibitor for at least 8 weeks or swallowed topical steroid (e.g., fluticasone propionate or oral budesonide suspension)? Yes No List						



South Dakota
Department of
Social Services

Mon-Sat: 7am to 7pm Central

Dupixent® Prior Authorization Request Form (Page 2 of 2) DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Eosinophilic	esophagitis
Has the patie	ent had a documented trial of a topical corticosteroids or antihistamines within the last 120 days? Yes No
List	
Quantity lim	
What is the q	uantity requested per TREATMENT? syringe_every weeks
	reason for exceeding the plan limitations? or loading dose purposes
☐ Requeste	on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime) d strength/dose is not commercially available
Are there any o this review?	ther comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to
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.