Reset Form Print Form

Prior Authorization Form

Dupixent®

Fax this form to: 1-800-424-3260

A fax cover sheet is not required.

Instructions: Please fill out all applicable sections on all pages completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the prior authorization). **Information contained in this form is Protected Health Information under HIPAA**.

☐ **NON-URGENT** ☐ **EXIGENT CIRCUMSTANCES**

MEMBER INFORMATION

Member's Last Name:

Member's First Name:

Member's Identification Number:

Date of Birth: ___ – ___ – ____

Member's Address:

City:

State:

ZIP:

PRESCRIBER INFORMATION

Prescriber's Last Name:

Prescriber's First Name:

National Provider Identifier (NPI) Number:

DEA Number:

Office Phone Number: ___ – ___ – ____

Office Fax Number: ___ – ___ – ____

CLINICAL CRITERIA

1. What medication is being requested?

   _____

2. Is the medication being prescribed by or in consultation with an allergist, immunologist, or dermatologist?
   ☐ Yes ☐ No

(Form continued on next page.)

Member's Last Name: | | | | | | | | | | | | |

Member's First Name: | | | | | | | | | | | | |

3. What is the member's diagnosis or medical condition? (Check all that apply.)
   - ☐ Moderate-to-severe atopic dermatitis
   - ☐ Chronic rhinosinusitis with nasal polyps (CRNP)
   - ☐ Antrochoanal polyps
   - ☐ Prior sino-nasal surgery
   - ☐ Bilateral symptomatic sino-nasal polyposis lasting at least 8 weeks
   - ☐ Septal deviation that occludes at least one nostril
   - ☐ Moderate/Severe asthma
   - ☐ Oral corticosteroid dependent asthma
   - ☐ Asthma with eosinophilic type and baseline blood eosinophil count ≥ 150 cells/mcL
   - ☐ Other _____
4. Has the member undergone any of the following trials? (Check all that apply.)
   - ☐ Topical Corticosteroid (or not a candidate)
   - ☐ Systemic corticosteroids within previous 2 years
   - ☐ Topical calcineurin inhibitor (e.g., tacrolimus or pimecrolimus)
   - ☐ Ineligible to receive or intolerant to systemic corticosteroids
   - ☐ Medium to high-dose inhaled corticosteroids
   - ☐ Additional controller medication for asthma (e.g., long-acting beta agonist)
5. Will the member be receiving live vaccines during therapy?
   - ☐ Yes ☐ No
6. Will the requested medication be used in combination with other anti-immunoglobulin E (IgE) therapy?
   - ☐ Yes ☐ No
7. Is there any other clinical information relevant to this request?

   _____

For a diagnosis of **chronic rhinosinusitis with nasal polyps** only**:**

8. Have other causes of nasal congestion/obstruction been ruled out (e.g., acute sinusitis, nasal or upper respiratory infection, rhinitis medicamentosa, tumors ,infections, granulomatosis) and has the physician assessed the member?
   - ☐ Yes ☐ No
9. Has the Physician assessed baseline disease severity utilizing an objective measure/tool?
   - ☐ Yes ☐ No

CLINICAL CRITERIA FOR RENEWALS

1. Has the member experienced any unacceptable toxicity from the drug?
   - ☐ Yes ☐ No

For **atopic dermatitis** only:

2. Has the member had a positive clinical response as indicated by improvement in signs and symptoms compared to baseline?
   - ☐ Yes ☐ No

(Form continued on next page.)

 MHID: MRXCOM11_01

Member's Last Name:

Member's First Name:

For **chronic rhinosinusitis with nasal polyps** only:

3. Has the member had a positive clinical response as indicated by improvement in signs and symptoms compared to baseline? This could be indicated in one or more of the following:
   - Nasal/obstruction symptoms
   - Improvement of sinus opacifications as assessed by CT-scans
   - An improvement on a disease activity scoring tool (e.g., nasal polyposis score [NPS], nasal congestion [NC] symptom severity score, sinonasal outcome test-22 [SNOT-22])

   ☐ Yes ☐ No

For **asthma** only:

4. Has the member shown improvement or exacerbation of asthma symptoms? This could be evidenced by one or more of the following:
   - Decreased use of systemic corticosteroids
   - Two-fold or greater decrease in inhaled corticosteroid use for at least 3 days
   - Hospitalizations/ER visits/unscheduled visits to healthcare provider
   - Improvement from baseline in FEV1

   ☐ Yes ☐ No

_____ _____

Prescriber Signature (Required) ***Date***

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

Fax this form to: 1-800-424-3260

Mail requests to:
Magellan Rx Management Prior Authorization Program
c/o Magellan Health, Inc.
4801 E. Washington Street
Phoenix, AZ 85034
Phone: 1-800-424-3312

 MHID: MRXCOM11_01