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
- ❑ Eosinophilic esophagitis
- ❑ Prurigo nodularis
- ❑ COPD with eosinophilic phenotype
- ❑ Other diagnosis: _____ ICD-10 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**

Atopic dermatitis:

Has the patient had a documented trial of a topical corticosteroid, pimecrolimus cream, tacrolimus ointment, Eurisa (crisaborole) ointment within the last 120 days? ❑ **Yes** ❑ **No** List _____

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**

List _____

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

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Eosinophilic esophagitis:

Has the patient had a documented trial for at least 8 weeks of a proton pump inhibitor or corticosteriod (e.g., fluticasone, budesonide suspension)? ❑ **Yes** ❑ **No** List _____

Prurigo nodularis

Has the patient had a documented trial of a topical corticosteroid, pimecrolimus cream, tacrolimus ointment, Eurisa (crisaborole) ointment within the last 120 days? ❑ **Yes** ❑ **No** List _____

Chronic obstructive pulmonary disease (COPD), (e.g., chronic bronchitis or emphysema) in patients with eosinophilic phenotype

List the patient's peripheral blood eosinophil levels _____ cells/mcL

Did the patient have two or more exacerbations requiring systemic corticosteroids and/or antibiotics within the past 12 months?
❑ **Yes** ❑ **No**

Did the patient require COPD-related emergency treatment (e.g., hospitalization in the past 12 months, mechanical ventilation)?
❑ **Yes** ❑ **No**

Is the patient currently receiving standard of care COPD treatment (i.e., ICS/LAMA/LABA)? ❑ **Yes** ❑ **No**

If yes, list all patient's medications _____

_____

If no, does the patient have contraindications? ❑ **Yes** ❑ **No**

List the contraindications experienced? _____

_____

Is the patient's post-bronchodilator FEV1/FVC ratio < 79%? ❑ **Yes** ❑ **No**

Will Dupixent be used as maintenance add-on therapy? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per TREATMENT? _____ syringe every _____ weeks

What is the reason for exceeding the plan limitations?

❑ Titration or loading dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ Other: _____

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.