carolina complete health

Dupixent for Atopic Dermatitis PA Request Form

Beneficiary Information

1. Beneficiary Last Name:_____2. First Name:_____

3. Beneficiary ID #:_____4. Beneficiary Date of Birth:_____5. Beneficiary Gender:_____

Prescriber Information

6. Prescribing Provider NPI#:_____

7. Requester Contact Information Name:_____Phone #:_____Ext:_____

Drug Information

8. Med requested: **Dupixent** 9a. Strength: _____ 9b. Quantity per 30 days _____

9c. Requested Duration (circle # days): ☐30 ☐60 ☐90 ☐120 ☐180

10. Is the beneficiary 18 years old or older? Yes_____No_____

11. Does the beneficiary have a diagnosis of moderate to severe Atopic Dermatitis? Yes_____No_____

12. Has the beneficiary failed at least 2 prescription topical steroids or has a documented adverse reaction or contraindication that precludes trial of at least 2 prescription topical steroids Yes_____No_____

List meds tried or reason topical steroids cannot be used.

_____

_____

13. Has the beneficiary tried and failed on either Protopic, Elidel, Eucrisa. or tacrolimus or has a documented adverse reaction or contraindication that precludes trial of either Protopic, Elidel, Eucrisa or tacrolimus? Yes____No__

List meds tried or reason Protopic, Elidel, Eucrisa, or tacrolimus cannot be used.

_____

_____

_____

(For continuation of therapy answer questions #1-#13 above and questions #13 and #14)

14. Has the beneficiary received continued clinical benefit from baseline supported by medical records? Yes__No__

15. Are medical records attached to this request that document clinical improvement from baseline? Yes__No__

Signature of Prescriber:_____Date: _____

(Prescriber signature mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax all forms and lab work to: (877) 386-4695 Pharmacy PA Call Center: (833) 585-4309