carolina complete health

Dupixent: Atopic Dermatitis

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. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____

11. Length of Therapy (in days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days

Clinical Information

1. Is the beneficiary 6 years of age or older? ☐ **Yes** ☐ **No**
2. Does the beneficiary have a diagnosis of moderate to severe Atopic Dermatitis? ☐ **Yes** ☐ **No**
3. Has the beneficiary failed at least one prescription topical steroid? ☐ **Yes** ☐ **No Please List:** _____

   _____
4. Does the beneficiary have a documented adverse reaction or contraindication that precludes trial of at least 1 prescription topical steroid? ☐ **Yes** ☐ **No Please List Contraindications:** _____

   _____
5. Does the beneficiary have a documented adverse reaction or contraindication that precludes trial of a topical calcineurin inhibitor (e.g., pimecrolimus (ages 2 and older) or tacrolimus 0.03% (ages 2 and older) and 0.1% (ages 18 and older))? ☐ **Yes** ☐ **No Please list Contraindications:** _____

   _____

For continuation of therapy, please answer questions 1-6

6. While on Dupixent, has the beneficiary had continued clinical benefit from baseline supported by medical records?

   ☐ **Yes** ☐ **No**

** Please provide medical records documenting the beneficiary's clinical benefit from baseline**

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.