# Dupixent for Nasal Polyps 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 member 18 years old or older? Yes__No____

11. Does the member have a diagnosis of chronic rhinosinusitis with nasal polyposis? Yes___ No_____

12. Has the member failed monotherapy with nasal steroids? Yes_____ No_____

List nasal steroids tried or reason nasal steroids cannot be used.

_____

_____

13. Has the member had previous sino-nasal surgery? Yes___No__

14. Has the member received treatment for nasal polyps with systemic corticosteroids in the past 2 years, or have contraindications to systemic corticosteroids?

Yes__No__

List nasal steroids tried or reason nasal steroids cannot be used (contraindications).

_____

_____

15. Will the member continue to receive intranasal steroids while receiving Dupixent? 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.