Pharmacy Request for Prior Approval – Dupixent: Asthma

SANDHILLS CENTER

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: ___up to 30 days ___60 days ___90 days ___120 days ___180 days ___365 days ___Other:_____

Clinical Information

1. Is the beneficiary 6 years of age or older? Yes___ No___
2. Does the beneficiary have a pre-treatment serum eosinophil count of 150 cells/mcL or greater at screening (within the past six weeks prior to the request for Dupixent) or 300 cells/mcL or greater within 12 months prior to use, or sputum eosinophilic count greater than 3%? Yes___ No___ Please list eosinophil count: _____
3. Does the beneficiary have oral corticosteroid dependent asthma with at least 1 month of daily oral corticosteroid use within the last 3 months? Yes___ No___
4. Does the beneficiary have inadequate control of asthma symptoms after a minimum of 3 months of compliant use of ONE of the following within the past 6 months: Inhaled corticosteroids and long acting beta2 agonist, or Inhaled corticosteroids and long-acting muscarinic antagonist? Yes___ No___
   Please list medication tried: _____
5. Will Dupixent be used for the relief of acute bronchospasm or status asthmaticus? Yes___ No___
6. Will Dupixent be used as dual therapy with another monoclonal antibody for the treatment of asthma? Yes___ No___

For continuation of therapy, please answer questions 1-7:

7. 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 current asthma status and response to Dupixent treatment**

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 to: 1-833-727-3741 or Call PerformRx for help: 1-888-846-1062