

Prior Authorization Request Form for Dupixent

FAX this completed form to (877) 386-4695

OR Mail requests to: Envolve Pharmacy Solutions PA Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720

I. PROVIDER INFORMATION		II. MEMBER INFORMATION	
Prescriber Name:		Member Name:	
Prescriber Specialty:		Identification #:	
Office Contact Name:		Group #:	
Group Name:		Date of Birth:	
Fax #:		Medication Allergies:	
Phone #:			
III. DRUG INFORMATION (One drug request per form)			
Drug name and strength:	Dosage Interval (sig):	Qty. per Day:	
IV. REQUIRED DOCUMENTATION (Detailed medical record documentation demonstrating evidence for each item must be submitted with prior authorization request)			
Specify diagnosis & diagnosis code relevant to this request:		Dx/Dx Code: _____	
Has the member received the appropriate vaccinations as recommended in the FDA-approved package insert, unless contraindicated?		<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit documentation.</i>	
Will the member be evaluated, treated and/or monitored for parasitic (helminth) infection before and/or during treatment?		<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit documentation.</i>	
Requests for all non-preferred medications: Does the member have a history of trial and failure of or contraindication or intolerance to the preferred Monoclonal Antibodies-Anti-IL, Anti-IgE? Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.		<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit documentation of previous trials/failures, contraindications, and/or intolerances or current use.</i>	
<input type="checkbox"/> If not prescribed by one of the following specialist, pulmonologist, allergist, immunologist, dermatologist, rheumatologist, otolaryngologist, etc., please indicate a specialist consulted: _____ <input type="checkbox"/> The requested medication will NOT be use concurrently with another Monoclonal Antibodies – Anti-IL, Anti-IgE agent (Fasenra, Nucala, Xolair, Cinqair, Dupixent) <input type="checkbox"/> If requesting for daily quantity exceeding daily limit (Refer to https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx), please provide supporting information: _____			
SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.			
ASTHMA:			
<input type="checkbox"/> Member has moderate to severe asthma despite maximal therapeutic doses of or intolerance or contraindication to asthma controller medications (please list asthma controller medications): _____ <input type="checkbox"/> Requested medication will be used with standard asthma controller medications (LABA, LAMA, ICS): _____ <input type="checkbox"/> If member has eosinophilic phenotype has an absolute blood eosinophil count of at least 150 cells/microL: _____			
ASTHMA RENEWAL REQUESTS:			
<input type="checkbox"/> Documented measurement improvement in severity of asthma evidenced by: _____ <input type="checkbox"/> Has a reduction of oral corticosteroid while maintaining asthma control			

- ☐ Member will continue to use standard asthma controller medications (LABA, LAMA, ICS): _____

CHRONIC MODERATE-TO-SEVERE ATOPIC DERMATITIS:

- ☐ Documented history of therapeutic failure, contraindication or intolerance to ALL the following: (medication, start date and end date)
- ☐ Phototherapy: _____
 - ☐ Systemic immunosuppressive (Cyclobenzaprime, Azathioprine, Methotrexate, Mycophenolate mofetil): _____
- ☐ Select all that apply (medication, start date and end date):
- ☐ For treatment of the face or skin folds, low-potency topical corticosteroids: _____
 - ☐ For treatment of other areas, medium to high-potency topical corticosteroids: _____
 - ☐ Topical calcineurin inhibitors: _____

CHRONIC MODERATE-TO-SEVERE ATOPIC DERMATITIS RENEWAL REQUESTS:

- ☐ Documented measurement improvement in severity of atopic dermatitis evidenced by: _____

CHRONIC RHINOSINUSITIS WITH NASAL POLYPOSIS (CRSwNP):

- ☐ Documented history of therapeutic failure, contraindication or intolerance to ALL the following: (medication, start date and end date)
- ☐ 14-day course of systemic glucocorticoids: _____
 - ☐ Sino-nasal surgery: _____
 - ☐ Maintenance nebulized or irrigated intranasal glucocorticoids: _____

CHRONIC RHINOSINUSITIS WITH NASAL POLYPOSIS (CRSwNP) RENEWAL REQUESTS:

- ☐ Documented measurement improvement in chronic rhinosinusitis with nasal polyposis disease activity evidenced by: _____

IV. ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION :

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.

Provider Signature: _____

Date: _____

Envolve Pharmacy Solutions will respond via fax or phone within 24 hours.

Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)