pa health & wellness

DUPIXENT (dupilumab) PRIOR AUTHORIZATION FORM *(form effective 1/5/2026)*

FAX this completed form to (844) 205-3386
OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720
OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/

Prior authorization guidelines for **Dupixent** and **Quantity Limits/Daily Dose Limits** are available on the PA Health & Wellness website at https://www.pahealthwellness.com/providers/pharmacy.html.

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Member name:		City/state/zip:	
Member ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested: Dupixent	Strength:	Formulation (pen, syringe, etc):	Weight: _____ lbs / kg	
Directions:			Quantity:	Refills:
Diagnosis (*submit documentation*):			Diagnosis code (*required*):	
Is Dupixent prescribed by or in consultation with a specialist (e.g., allergist, dermatologist, hematologist/oncologist, immunologist, pulmonologist, rheumatologist, etc.)?			☐Yes ☐No	*Submit documentation of consultation, if applicable.*

Complete the section(s) below applicable to the member and this request and SUBMIT DOCUMENTATION for each item.

INITIAL requests

1. **For treatment of ASTHMA:** Indicate which of the following apply to the member. *Check all that apply.*
   - ☐At least ONE of the following:
     - ☐Has a diagnosis of asthma with an eosinophilic phenotype with an absolute blood eosinophil count ≥150 cells/microliter
     - ☐Has a diagnosis of oral corticosteroid-dependent asthma
   - ☐Has asthma that is moderate-to-severe
   - ☐Has tried or cannot use standard asthma controller medications (e.g., inhaled corticosteroids, inhaled long-acting beta agonists [LABAs], etc.)
   - ☐Will use Dupixent in addition to tolerated standard asthma controller medications (e.g., inhaled corticosteroids, inhaled LABAs, etc.)

2. **For treatment of chronic ATOPIC DERMATITIS (AD):** Indicate which of the following apply to the member. *Check all that apply.*
   - ☐Has at least ONE of the following:
     - ☐A BSA of ≥10% that is affected
     - ☐Involvement of critical areas (e.g., face, feet, genitals, hands, intertriginous areas, scalp)
     - ☐Significant disability or impairment of physical, mental, or psychosocial functioning
   - ☐Tried and failed or cannot try (due to intolerance or contraindication) BOTH of the of the following:
     - ☐ONE of the following:

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- ☐ For the face, skin folds, or other critical areas, a 4-week trial of a low-potency (or higher) topical corticosteroid
- ☐ For other body areas, a 4-week trial of a medium potency or higher topical corticosteroid
- ☐ An 8-week trial of a topical calcineurin inhibitor (eg, pimecrolimus, tacrolimus)

3. **For treatment of CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD):**
   - ☐ Has COPD that is inadequately controlled on standard COPD controller medications (e.g., inhaled steroids, inhaled LABAs, etc.)
   - ☐ Will use Dupixent as an add-on maintenance treatment
   - ☐ Has a diagnosis of COPD with an eosinophilic phenotype

4. **For treatment of CHRONIC RHINOSINUSITIS WITH NASAL POLYPOSIS (CRSwNP):**
   - ☐ Has CRSwNP that is inadequately controlled on topical intranasal corticosteroids
   - ☐ Will use Dupixent as an add-on maintenance treatment

5. **For treatment of EOSINOPHILIC ESOPHAGITIS (EOE):**
   - ☐ Has tried and failed or cannot try (due to intolerance or contraindication) a proton pump inhibitor (eg, omeprazole, lansoprazole, etc)

6. **For treatment of PRURIGO NODULARIS (PN):**
   - ☐ Has a history of pruritis for at least 6 weeks
   - ☐ Has PN associated with at least ONE of the following:
     - ☐ ≥20 nodular lesions
     - ☐ Significant disability or impairment of physical, mental, or psychosocial functioning

7. **For treatment of BULLOUS PEMPHIGOID:**
   - ☐ Has ONE of the following:
     - ☐ Tried and failed or has a contraindication or an intolerance to systemic corticosteroids
     - ☐ Has corticosteroid-dependent disease
   - ☐ Tried and failed a corticosteroid-sparing therapy (e.g., doxycycline, dapsone, methotrexate, mycophenolate, azathioprine) or has a contraindication or an intolerance to these therapies

8. **Other diagnosis – specify:** _____

List other treatments tried (including start/stop dates, dose, outcomes, etc.): _____

_____

RENEWAL requests

1. **For the treatment of ASTHMA:**
   - ☐ Has documented measurable evidence of improvement in the member's asthma
   - ☐ Maintained asthma control while decreasing the oral corticosteroid dose
   - ☐ Is using Dupixent in addition to tolerated standard asthma controller medications (e.g., inhaled corticosteroids, inhaled LABAs, etc.)

2. **For the treatment of ALL OTHER diagnoses:**
   - ☐ Has documented evidence of improvement in disease severity

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO 844-205-3386

Prescriber Signature:	**Date**:

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Pharmacy Department 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.)