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 DOCUMENTION *(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?	☐ Yes ☐ No	*Submit documentation.*
Will the member be evaluated, treated and/or monitored for parasitic (helminth) infection before and/or during treatment?	☐ Yes ☐ No	*Submit documentation.*
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.*	☐ Yes ☐ No	*Submit documentation of previous trials/failures, contraindications, and/or intolerances or current use.*

- ☐ If not prescribed by one of the following specialist, pulmonologist, allergist, immunologist, dermatologist, rheumatologist, otolaryngologist, etc., please indicate a specialist consulted:_____
- ☐ The requested medication will NOT be use concurrently with another Monoclonal Antibodies – Anti-IL, Anti-IgE agent (Fasenra, Nucala, Xolair, Cinqair, Dupixent)
- ☐ 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:

- ☐ Member has moderate to severe asthma despite maximal therapeutic doses of or intolerance or contraindication to asthma controller medications (please list asthma controller medications):
  _____
- ☐ Requested medication will be used with standard asthma controller medications (LABA, LAMA, ICS):_____
- ☐ If member has eosinophilic phenotype has an absolute blood eosinophil count of at least 150 cells/microL:_____

ASTHMA RENEWAL REQUESTS:

- ☐ Documented measurement improvement in severity of asthma evidenced by: _____
- ☐ 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 (Cyclobenzaprine, 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.)