health information designs

Dupixent
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a new prescription for Dupixent must meet criteria for coverage, as stated in the PA Criteria page of the North Dakota Medicaid Prior Authorization website (www.hidesigns.com/ndmedicaid) or directly at the following link: http://www.hidesigns.com/assets/files/ndmedicaid/2018/Criteria/PA_Criteria.pdf

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug:	**Diagnosis for this request:**	**Is the affected area is on the face, groin, axilla, or under occlusion?** □ YES □ NO
List all failed medications:	**Start Date:**	**End Date:**

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #