Acentra HEALTH

Prior Authorization Vendor for ND Medicaid

Dupixent
Prior Authorization Form

Fax completed form to:
855-207-0250
For questions regarding this prior authorization, call
866-773-0695

ND Medicaid requires that members receiving a prescription for Dupixent to meet specific clinical criteria for coverage which can be found at https://ndmedicaid.acentra.com/ndpdl/

Member Name	Member Date of Birth	Weight (kg)	Member Medicaid ID Number
Prescriber Name	Prescriber NPI	Specialist involved in therapy *(only applicable if criteria requires)*	
Telephone Number	Fax Number	Address	
Diagnosis for the Request:	City	State	Zip Code
Requested Drug, Strength, and Directions:		**Dosage Form (e.g., tablet):**	

SECTION A: Atopic Dermatitis

1. Is the affected area on the face, groin, axilla, or under occlusion? ☐ YES ☐ NO

SECTION B: Eosinophilic esophagitis

1. Has the member had ≥15 intraepithelial eosinophils per high-power field (eos/hpf)? ☐ YES ☐ NO
2. *Renewal request only:* Has the member achieved a significant reduction in dysphagia symptoms? ☐ YES ☐ NO
3. *Renewal request only:* Has the member achieved an esophageal intraepithelial eosinophil count of <6 eos/hp? ☐ YES ☐ NO

SECTION C: Nasal polyps

1. Does the member have bilateral polyps confirmed by sinus CT, sinus MRI, or nasal endoscopy? ☐ YES ☐ NO
2. *Renewal request only:* Has the member achieved significant reduction in polyp size and symptoms? ☐ YES ☐ NO

SECTION D: Prurigo nodularis

1. Has the member experienced nodular lesions that produce itch for greater than 6 weeks that has significantly diminished quality of life, including sleep disturbances? ☐ YES ☐ NO

List all failed medications:	**Start Date:**	**End Date:**

Renewal Requests only: assessment of the member's clinical benefit since starting the requested agent

☐ *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 member.*

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 member'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.*