



**Dupixent
Prior Authorization Form**

Fax completed form to: 855-207-0250 For questions regarding this prior authorization, call 866-773-0695
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Prior Authorization Vendor for ND Medicaid
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ND Medicaid requires that members 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 <http://www.hidesigns.com/ndmedicaid> or directly at the following link: <http://www.hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf>

Part I: TO BE COMPLETED BY PRESCRIBER REPRESENTATIVE

Member Name	Member Date of Birth	Weight (kg)	Member Medicaid ID Number
Prescriber Name	Specialist involved in therapy (if not treating prescriber)		
Prescriber NPI	Telephone Number	Fax Number	
Requested Drug:		Diagnosis for this request:	
<input type="checkbox"/> Atopic dermatitis:	Is the affected area on the face, groin, axilla, or under occlusion? <input type="checkbox"/> YES <input type="checkbox"/> NO		
<input type="checkbox"/> Asthma:	Has the member had at least 1 asthma exacerbation requiring use of oral corticosteroids in previous year despite continued compliant use of a moderate to high dose inhaled steroid in combination with a long-acting beta agonist (LABA) and long-acting muscarinic antagonist (LAMA) as evidenced by paid claims or pharmacy printouts? <input type="checkbox"/> YES <input type="checkbox"/> NO		
<input type="checkbox"/> Eosinophilic esophagitis:	Has the member had ≥ 15 intraepithelial eosinophils per high-power field (eos/hpf). <input type="checkbox"/> YES <input type="checkbox"/> NO		
<input type="checkbox"/> Nasal polyps:	Does the member have bilateral polyps confirmed by sinus CT, sinus MRI, or nasal endoscopy? <input type="checkbox"/> YES <input type="checkbox"/> NO		
<input type="checkbox"/> Prurigo nodularis:	Has the member experienced nodular lesions that produce itch for greater than 6 weeks that has significantly diminished quality of life, including sleep disturbances. <input type="checkbox"/> YES <input type="checkbox"/> NO		
List all failed medications:	Start Date:	End Date:	
<input type="checkbox"/> 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
<i>**: 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.</i>			

Part II: TO BE COMPLETED BY PHARMACY

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