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 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: www.hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf

Part I: TO BE COMPLETED BY PRESCRIBER/PRESCRIBER'S OFFICE

Recipient Name	Recipient Date of Birth	Recipient 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:**	

For atopic dermatitis:	**Is the affected area on the face, groin, axilla, or under occlusion?** ☐ YES ☐ NO
For 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?** ☐ YES ☐ NO
For nasal polyps:	**Does the member have bilateral polyps confirmed by sinus CT, sinus MRI, or nasal endoscopy?** ☐ YES ☐ NO
	Has the member had a 12-week trial of intranasal or oral corticosteroid? ☐ 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 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.*

Part II: TO BE COMPLETED BY PHARMACY

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