

**NC Medicaid
Pharmacy Prior Approval Request for
Dupixent: Atopic Dermatitis**

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): up to 30 Days 60 Days 90 Days 120 Days 180 Days

Clinical Information

1. Is the beneficiary 6 years of age or older? Yes No
2. Does the beneficiary have a diagnosis of moderate to severe Atopic Dermatitis? Yes No
3. Has the beneficiary failed at least one prescription topical steroid? Yes No **Please List:** _____
4. Does the beneficiary have a documented adverse reaction or contraindication that precludes trial of at least 1 prescription topical steroid? Yes No **Please List Contraindications:** _____
5. Does the beneficiary have a documented adverse reaction or contraindication that precludes trial of a topical calcineurin inhibitor (e.g., pimecrolimus (ages 2 and older) or tacrolimus 0.03% (ages 2 and older) and 0.1% (ages 18 and older))? Yes No **Please list Contraindications:** _____

For continuation of therapy, please answer questions 1-6

6. While on Dupixent, has the beneficiary had continued clinical benefit from baseline supported by medical records?
 Yes No

**** Please provide medical records documenting the beneficiary's clinical benefit from baseline****

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.