OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Dupixent® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Moderate to severe asthma
- ❑ Moderate to severe chronic atopic dermatitis
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Prescriber's Specialty:

Select if Dupixent is prescribed by or in consultation with one of the following specialists:

- ❑ Dermatologist
- ❑ Allergist/immunologist

For moderate to severe asthma, answer the following:

Is the patient currently dependent on oral corticosteroids for the treatment of asthma? ❑ **Yes** ❑ **No**

Does the patient have asthma of eosinophilic phenotype as defined by baseline (pre-Dupixent treatment) peripheral blood eosinophil level greater than or equal to 150 cells per microliter within the past 6 weeks? ❑ **Yes** ❑ **No**

Has the patient had at least one or more asthma exacerbations requiring systemic corticosteroids within the past 12 months? ❑ **Yes** ❑ **No**

Has the patient had any prior intubation for an asthma exacerbation? ❑ **Yes** ❑ **No**

Has the patient had prior asthma-related hospitalization within the past 12 months? ❑ **Yes** ❑ **No**

Select if the patient is **being treated** or has **contraindication** or **intolerance** to the following:

- ❑ High-dose inhaled corticosteroid (ICS) (e.g., greater than 500 mcg fluticasone propionate equivalent/day)
- ❑ Additional asthma controller medication (e.g., leukotriene receptor antagonist, long-activing beta-2 agonist [LABA], theophylline)
- ❑ One maximally-dosed combination ICS/LABA product (e.g., Advair [fluticasone propionate/salmeterol], Dulera [mometasone/formeterol], Symbicort [budesonide/formoterol])

Reauthorization:

Is there documentation the patient has had a positive clinical response to Dupixent therapy (e.g., reduction in exacerbations)? ❑ **Yes** ❑ **No**

Select if the patient is **being treated** or has **contraindication** or **intolerance** to the following:

- ❑ High-dose inhaled corticosteroid (ICS) (e.g., greater than 500 mcg fluticasone propionate equivalent/day)
- ❑ Additional asthma controller medication (e.g., leukotriene receptor antagonist, long-activing beta-2 agonist [LABA], theophylline)
- ❑ One maximally-dosed combination ICS/LABA product (e.g., Advair [fluticasone propionate/salmeterol], Dulera [mometasone/formeterol], Symbicort [budesonide/formoterol])

Dupixent® Prior Authorization Request Form (Page 2 of 2)

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For moderate to severe chronic atopic dermatitis, answer the following:

Has the patient had trial and failure, contraindication, or intolerance to ONE medium to high potency topical corticosteroid? ❑ **Yes** ❑ **No**

Select if the patient has had trial and failure or intolerance to the following, unless the patent is not a candidate for therapy (e.g., immunocompromised):

- ❑ Elidel (pimecrolimus) topical cream
- ❑ Tacrolimus topical ointment

Reauthorization:

Is there documentation the patient has had a positive clinical response to Dupixent therapy (e.g., reduction in body surface area involvement, reduction in pruritus severity)? ❑ **Yes** ❑ **No**

Quantity Limit Requests:

What is the quantity requested per MONTH? _____

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.