PRO ACT
PHARMACY BENEFIT MANAGEMENT

1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

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

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			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 chronic atopic dermatitis
❑ Other diagnosis:____________________ICD-10 Code(s): ____________________

Clinical Information:
Select if Dupixent is prescribed by or in consultation with one of the following specialists:
- ❑ Dermatologist
- ❑ Allergist/immunologist

Does the patient have history of failure, contraindication, or intolerance to one medium to high potency topical corticosteroid? ❑ **Yes** ❑ **No**

Select if the patient has history of 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:
If this is a reauthorization request, answer the following question:
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 atbedtime)
❑ Requested strength/dose is not commercially available
❑ Other: ____________________

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

____

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Please note: This request may be denied unless all required information is received.

Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.

Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.

I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): ______________________________________ **Date:** ______________

PROACT INTERNAL USE ONLY:					
Clinical Review Decision					
	Approved, through				
	Denied (documentation attached, if necessary)				
Tracking:					
1st Attempt		2nd Attempt		Letter Mailed:	

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