NC Medicaid Pharmacy Request for Prior Approval Dupixent-ASTHMA

Beneficiary Information

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

Prescriber Information

7. Prescribing Provider NPI #: _____
8. Prescriber DEA #: _____

Requester Contact Information
Name:_____ Phone #:_____ Ext.: _____

Drug Information

9. Drug Name: _____ 10. Strength:_____ 11. Quantity Per 30 Days: _____

12. Length of Therapy (in days): ☐ up to 30 ☐ 60 ☐ 90 ☐ 120 ☐ 180

Clinical Information

For initial therapy:
Asthma (answer questions 1-7)

1. Is the beneficiary age 12 or greater? ☐ Yes ☐ No
2. Does the beneficiary have **a diagnosis of Asthma with eosinophilic phenotype with a pre-treatment serum eosinophil count of 150 cells/mcL or greater at screening (within the past six weeks prior to the request for Dupixent) or 300 cells/mcL or greater within 12 months prior to use, or sputum eosinophilic count greater than 3%?** ☐ Yes ☐ No Please list eosinophilic count. _____
3. Does the beneficiary have Oral-corticosteroid-dependent asthma with at least 1 month of daily oral corticosteroid use within the last 3 months? ☐ Yes ☐ No
4. Is the beneficiary experiencing inadequate control of asthma symptoms after a minimum of 3 months of compliant use of **one** of the following:
   a. Inhaled corticosteroids and long acting beta2 agonist ☐ Yes ☐ No
   b. Inhaled corticosteroids and long acting muscarinic antagonist ☐ Yes ☐ No
5. Is Dupixent being used for the relief of acute bronchospasm or status asthmaticus? ☐ Yes ☐ No
6. Is Dupixent being used as dual therapy with another monoclonal antibody for the treatment of Asthma?
   ☐ Yes ☐ No

For continuation of therapy:
Asthma (answer questions 1-7 above and answer questions 7 & 8)

7. Has the beneficiary experienced clinical benefit as evidenced by a documented response of decreased asthma exacerbations from baseline? ☐ Yes ☐ No
8. Are medical records attached to this request that document the beneficiary's current asthma status and response to Dupixent treatment? ☐ Yes ☐ No

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.

Fax this form to NCTracks at (855) 710-1969 Pharmacy PA Call Center: (866) 246-8505