mercy care

Fax completed prior authorization request form to 800-854-7614 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.mercycareaz.org/providers/pharmacy.html

Dupixent
Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs, and medical testing relevant to request showing medical justification to support diagnosis

Member Information			
Member Name (first & last):	Date of Birth:	Gender: ☐ Male ☐ Female	Height:
Member ID:	City:	State:	Weight:

Prescribing Provider Information			
Provider Name (first & last):	Specialty:	NPI#	DEA#
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone	Office Fax:	

Dispensing Pharmacy Information		
Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information				
Medication request is NOT for an FDA approved, or compendia-supported diagnosis (circle one): ☐ Yes ☐ No	Diagnosis:	ICD-10 Code:		
Are there any contraindications to formulary medications? If yes, please specify:	☐ Yes	☐ No	☐ New request	☐ Continuation of therapy request

Directions for Use:	Strength:	Dosage Form:
	Quantity: / Day Supply:	Duration of Therapy/Use:

What medication(s) has the member tried and failed for this diagnosis? Please specify below.

Turn-Around Time for Review	
☐ Standard – (24 hours)	☐ **Urgent** – waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____

Clinical Information

☐ **Atopic Dermatitis**

Is the diagnosis MODERATE to SEVERE chronic atopic dermatitis confirmed with submission of documentation (for example chart notes)?	☐ Yes	☐ No

There is a history of T/F, C/I, or intolerance to the following:	☐ One topical calcineurin inhibitor (Elidel or Protopic) ☐ One topical corticosteroid (mometasone furoate, fluocinolone acetonide (generic Synalar), fluocinonide) ☐ Eucrisa ☐ Opzelura ☐ Vtama ☐ Zoryve ☐ Adbry

Is Dupixent being given w/COMBO such as Xolair, Rituxan, Enbrel, OR Remicade / Inflectra?	☐ Yes	☐ No

☐ **Renewal Request ONLY**

Is there documentation of positive clinical response to therapy?	☐ Yes	☐ No

There is a history of T/F, C/I, or intolerance to the following:	☐ One topical calcineurin inhibitor (Elidel or Protopic) ☐ One topical corticosteroid (mometasone furoate, fluocinolone acetonide (generic Synalar), fluocinonide) ☐ Eucrisa ☐ Opzelura

	☐ Vtama ☐ Zoryve ☐ Adbry			
Is Dupixent being given w/COMBO such as Xolair, Rituxan, Enbrel, OR Remicade/Inflectra?	☐ Yes	☐ No		
☐ **Asthma**				
Is there documentation confirming diagnosis of MODERATE to SEVERE asthma?	☐ Yes	☐ No		
Asthma is uncontrolled by at least ONE of the following:	☐ Poor symptom control ACQ score >1.5 OR ACT score <20	☐ ≥2 bursts of systemic steroids for at least 3 days each in the previous year	☐ Asthma-related emergency treatment (ER visit, hospital admission, OR unscheduled physician's office visit for nebulizer or other urgent treatment)	
	☐ Patient is currently dependent on oral corticosteroids for the treatment of asthma	☐ Airflow limitation (after appropriate bronchodilator withhold FEV1 <80% predicted [in face of reduced FEV1 / FVC defined as < lower limit of normal)		
Used in COMBO with ONE of the following:	ONE high-dose COMBO ICS/LABA ☐ Advair/AirDuo Respiclick ☐ Symbicort ☐ Breo Ellipta	COMBO therapy includes BOTH of the following:	ONE high-dose ICS product: ☐ Alvesco ☐ Asmanex ☐ QVAR	ONE additional asthma controller ☐ LABA - Striverdi or Arcapta ☐ Singulair ☐ theophylline
Is there documentation that asthma is an eosinophilic phenotype as defined by a baseline peripheral blood eosinophil level ≥150 cells/mL within the past 6 weeks?	☐ Yes	☐ No		
Is there currently a dependency on oral steroids for asthma?	☐ Yes	☐ No	Is the member currently on Dupixent?	☐ Yes ☐ No
Is Dupixent being received in COMBO with ONE of the following?	Anti-interleukin-5 therapy: ☐ Nucala ☐ Cinqair ☐ Fasenra ☐ N/A	Anti-IgE therapy: ☐ Xolair ☐ N/A		
☐ **Renewal Request ONLY**				
Documentation of positive clinical response to therapy with at least ONE of the following:	☐ Reduction in frequency of exacerbations	☐ Decreased use of rescue medications	☐ Increased % predicted FEV1 from baseline	☐ Reduction in severity / frequency of symptoms ☐ Reduction in oral steroid requirements
Is Dupixent being received in COMBO with ONE of the following?	Anti-interleukin-5 therapy: ☐ Nucala ☐ Cinqair ☐ Fasenra ☐ N/A	Anti-IgE therapy: ☐ Xolair ☐ N/A		
Is Dupixent being used in COMBO with an ICS-containing controller medication?	☐ Yes	☐ No		
☐ **Chronic Rhinosinusitis with Nasal Polyposis**				
Is there documentation confirming diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP)?	☐ Yes	☐ No		
Which TWO or more of the following symptoms have been present ≥12 weeks?	☐ Mucopurulent discharge	☐ Nasal obstruction and congestion	☐ Decreased or absent sense of smell	☐ Facial pressure or pain
Is there evidence with ONE of the following?	☐ Inflammation on paranasal sinus exam OR computed tomography	☐ Purulence coming from paranasal sinuses OR osteomata complex		
Is there presence of nasal polyps?	☐ Yes	☐ No	Member meets ONE of the following:	☐ Prior sino-nasal surgery ☐ Systemic steroids in previous 2 years
Is Dupixent being received in COMBO with ONE of the following?	Anti-interleukin-5 therapy: ☐ Nucala ☐ Cinqair ☐ Fasenra ☐ N/A	Anti-IgE therapy: ☐ Xolair ☐ N/A	Was there symptom relief after trial of ALL of the following:	☐ Nasal saline irrigation ☐ N/A Antileukotriene agents: ☐ Montelukast ☐ Zafirlukast ☐ Zileuton ☐ N/A Intranasal steroids: ☐ fluticasone ☐ mometasone ☐ triamcinolone ☐ N/A
Is the member currently on Dupixent therapy?	☐ Yes	☐ No	Will Dupixent be given as an add-on maintenance therapy in COMBO with intranasal corticosteroids?	☐ Yes ☐ No
☐ **Renewal Request ONLY**				
Is there documentation confirming positive clinical response to therapy?	☐ Yes	☐ No	Will Dupixent continue to be used as add on therapy to intranasal corticosteroids?	☐ Yes ☐ No
Is Dupixent being received in COMBO with ONE of the following?	Anti-interleukin-5 therapy ☐ Nucala ☐ Cinqair ☐ Fasenra ☐ N/A	Anti-IgE therapy ☐ Xolair ☐ N/A		

☐ **Eosinophilic Esophagitis (EoE)**			
Is there documentation confirming a diagnosis of eosinophilic esophagitis (EoE)?		☐ Yes	☐ No
Does the member have symptoms of esophageal dysfunction?		☐ Yes	☐ No
Is there documentation confirming the member has at least 15 intraepithelial eosinophils per high power field (HPF)?		☐ Yes	☐ No
Have other causes of esophageal eosinophilia been excluded?		☐ Yes	☐ No
Documentation confirming T/F, C/I, or intolerance to at least an 8-week trial of ONE of the following:	☐ Proton pump inhibitors (for example, pantoprazole, omeprazole),	☐ Topical (esophageal) corticosteroids (for example, budesonide, fluticasone)	
☐ **Renewal Request ONLY**			
Documentation confirming positive clinical response to therapy as evidenced by improvement of at least ONE of the following from baseline:	☐ Symptoms (dysphagia, food impaction, heartburn, chest pain),	☐ Histologic measures (esophageal intraepithelial eosinophil count)	☐ Endoscopic measures (edema, furrows, exudates, rings, strictures)
☐ **Prurigo Nodularis (PN)**			
Is there documentation confirming a diagnosis of Prurigo Nodularis (PN)?		☐ Yes	☐ No
Does the member have at least 20 nodular lesions?		☐ Yes	☐ No
Is there documentation confirming T/F, C/I, or intolerance to ONE previous PN treatment (topical corticosteroids, topical calcineurin inhibitors, [pimecrolimus, tacrolimus}, topical capsaicin)?		☐ Yes	☐ No
☐ **Renewal Request ONLY**			
Documentation confirming positive clinical response to therapy as evidenced by improvement of at least ONE of the following:	☐ Reduction of nodular lesions from baseline	☐ Improvement in symptoms (pruritis, inflammation) from baseline	
☐ **Chronic Obstructive Pulmonary Disease**			
Are there medical records (e.g., chart notes) confirming diagnosis of COPD?		☐ Yes	☐ No
Are there medical records (e.g., chart notes) confirming the presence of Type 2 inflammation evidenced by blood eosinophils greater than or equal to 300 cells per microliter at baseline?		☐ Yes	☐ No
There are paid claims or medical records (e.g., chart notes) confirming the patient is receiving ONE of the following therapies at maximally tolerated doses?	☐ Triple therapy (i.e., ICS, LAMA and a LABA	☐ ICS are contraindicated ☐ LAMA + LABA	
Does the patient have post-bronchodilator FEV1 / FVC ratio < 0.70?	☐ Yes	☐ No	
☐ At least 2 exacerbations where systemic were required at least once within the past 12 months	☐ A COPD-related hospitalization- within the past 12 months		
Are there medical records (e.g., chart notes) confirming the patient experiences dyspnea during everyday activities (e.g., needs to stop for breath when walking on level ground)?		☐ Yes	☐ No
☐ **Renewal Request ONLY**			
Are there medical records (e.g., chart notes) confirming a positive clinical response to therapy (e.g., improved lung function, a reduction in COPD exacerbations)?		☐ Yes	☐ No
There are paid claims or medical records (for example, chart notes) confirming the member is receiving ONE of the following therapies?	☐ Triple therapy (i.e., ICS, LAMA and a LABA	☐ ICS are contraindicated ☐ LAMA + LABA	
☐ **Chronic Spontaneous Urticaria**			
Is the diagnosis of Chronic Spontaneous Urticaria confirmed with submission of documentation (for example chart notes)?		☐ Yes	☐ No
Have symptoms of itching & hives persisted for at least 4 consecutive weeks despite titrating to an optimal dose with a 2nd generation H1 antihistamine such ascetirizine, fexofenadine, unless there is a C/I or intolerance to H1 antihistamines?		☐ Yes	☐ No
Was concurrent use with an H1 antihistamine, confirmed by EITHER paid claims OR documentation such as chart notes, unless there is a contraindication or intolerance to H1 antihistamines?		☐ Yes	☐ No
Was a trial with at least TWO of the following therapies confirmed to have an inadequate response or intolerance by EITHER paid claims OR documentation such as chart notes?	☐ Doxepin ☐ H1 antihistamine ☐ H2 antagonist (e.g., famotidine, cimetidine) ☐ Hydroxyzine ☐ Leukotriene receptor antagonist (e.g., montelukast)		
Was a history of failure, C/I, or intolerance to Xolair demonstrated by paid claims OR submission of documentation such as chart notes)?		☐ Yes	☐ No
☐ **Renewal Request ONLY**			
Was the patient's disease status re-evaluated since the last authorization to confirm condition warrants continued treatment?		☐ Yes	☐ No
Was a history of failure, C/I or intolerance to Xolair demonstrated by paid claims OR submission of documentation such as chart notes?		☐ Yes	☐ No
Is there documentation such as chart notes confirming the member has experienced at least ONE of the following:	☐ Reduction in itching severity from baseline	☐ Reduction in the number of hives from baseline	
☐ **Bullous Pemphigoid (BP)**			
Have medical records been submitted confirming a diagnosis of bullous pemphigoid (BP) as confirmed by skin biopsy or serology?		☐ Yes	☐ No

Will Dupixent be used in combination with a tapering course of oral corticosteroids (e.g. prednisone) until disease control has occurred?			☐ Yes	☐ No
☐ **Renewal Request ONLY**				
Is there documentation of positive clinical response to therapy (e.g. decreased pruritic severity from baseline, no new lesions or worsening of old lesions?			☐ Yes	☐ No
☐ **Allergic Fungal Rhinosinusitis**				
Are there medical records (for example, chart notes) confirming the following:	☐ Diagnosis of allergic fungal rhinosinusitis	☐ A history of sino-nasal surgery		
Are there medical records (for example, chart notes) confirming ONE of the following:	☐ Inadequate response to a trial (minimum 30-day supply) of appropriate post-operative management for allergic fungal rhinosinusitis (for example, systemic glucocorticoids [for example, prednisone], intranasal glucocorticoids [for example, budesonide]).	☐ Contraindication to appropriate post-operative management for allergic fungal rhinosinusitis (for example, systemic glucocorticoids [for example, prednisone], intranasal glucocorticoids [for example, budesonide]).		
Is Dupixent being used in combination with another biologic medication (for example, Xolair [omalizumab], Nucala [mepolizumab], Cinqair [reslizumab], Fasenra [benralizumab])?			☐ Yes	☐ No
☐ **Renewal Request ONLY**				
Are there medical records (for example, chart notes) confirming a positive clinical response to Dupixent therapy (for example, reduction in sinus opacification)?			☐ Yes	☐ No
Is Dupixent being used in combination with another biologic medication (for example, Xolair [omalizumab], Nucala [mepolizumab], Cinqair [reslizumab], Fasenra [benralizumab])?			☐ Yes	☐ No
Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records				

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ **Date:** _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Standard turnaround time is 24 hours. You can call 800-624-3879 to check the status of a request.