AmeriHealth Caritas North Carolina

# Pharmacy Request for Prior Approval – Dupixent: Nasal Polyps

**Beneficiary Information**

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

**Prescriber Information**

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

**Drug Information**

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: ___up to 30 days ___60 days ___90 days ___120 days ___180 days ___365 days ___Other:_____

**Clinical Information**

1. Is the beneficiary 18 years of age or older? Yes___ No___
2. Does the beneficiary have a diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP)? Yes___ No___
3. Has the beneficiary failed monotherapy with nasal steroids? Yes___ No___
4. Has the beneficiary had treatment for nasal polyps with systemic corticosteroids in the past 2 years, or have contraindications to systemic corticosteroids? Yes___ No___
Please List tried systemic corticosteroids or contraindications: _____
_____
5. Will the beneficiary continue to receive intranasal steroids in conjunction with Dupixent? Yes___ No___

**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 current Nasal Polyps status and response to Dupixent treatment****

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: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406**