UnitedHealthcare Community Plan

NC Pharmacy Prior Approval Request for
Dupixent: Atopic Dermatitis

Beneficiary Information

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

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. ____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days:_____
11. Length of Therapy (in days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days

Clinical Information

1. Is the beneficiary 6 years of age or older? ☐ **Yes** ☐ **No**
2. Does the beneficiary have a diagnosis of moderate to severe Atopic Dermatitis? ☐ **Yes** ☐ **No**
3. Has the beneficiary failed at least two prescription topical steroids? ☐ **Yes** ☐ **No Please List:** _____
   _____
4. Does the beneficiary have a documented adverse reaction or contraindication that precludes trial of at least 2 prescription topical steroids? ☐ **Yes** ☐ **No Please List Contraindications:** _____
   _____
5. Has the beneficiary tried and failed Protopic, Elidel, Eucrisa or tacrolimus? ☐ **Yes** ☐ **No**
6. Does the beneficiary have a documented adverse reaction or contraindication that precludes trial of either Protopic, Elidel, Eucrisa or tacrolimus? ☐ **Yes** ☐ **No Please list Contraindications:** _____
   _____

For continuation of therapy, please answer questions 1-8

7. 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 clinical benefit from baseline**

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 1-866-940-7328 Pharmacy PA Call Center: 1-855-258-1593