



**NC Medicaid  
Pharmacy Prior Approval Request for  
Monoclonal Antibodies: Dupixent for Asthma**

**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  365 Days  Other \_\_\_\_\_

**Clinical Information**

1. Is the beneficiary age 6 years of age or older?  **Yes**  **No**
2. Does the beneficiary have 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)?  **Yes**  **No** Please list eosinophil 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. Does the beneficiary have inadequate control of asthma symptoms after a minimum of 3 months of compliant use within the past 6 months of Inhaled corticosteroids and a long acting beta2 agonist?  **Yes**  **No Please list medication tried:** \_\_\_\_\_
5. Will Dupixent be used for the relief of acute bronchospasm or status asthmaticus?  **Yes**  **No**
6. Will the beneficiary receive dual therapy with another monoclonal antibody for the treatment of asthma?  
 **Yes**  **No**

**For continuation of therapy, please answer questions 1-7**

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 current asthma 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.

Please fax this form to 1-800-678-3189

Pharmacy PA Call Center: 1-866-799-5318