**NC Medicaid**
**Pharmacy Prior Approval Request for**
## Monoclonal Antibodies: Dupixent for Eosinophilic Esophagitis

**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 12 years of age or older? ☐ **Yes** ☐ **No**
2. Does the beneficiary have a diagnosis of Eosinophilic Esophagitis? ☐ **Yes** ☐ **No**
3. Has the beneficiary tried and failed, or has contraindication, or intolerance to Proton Pump Inhibitors or steroids delivered topically via inhaler, liquid, or tablet? ☐ **Yes** ☐ **No**

**For continuation of therapy, please answer questions 1-4**

4. 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 Eosinophilic Esophagitis 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.