



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

**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 18 years of age or older?  Yes  No
  2. Does the beneficiary have a diagnosis of Prurigo Nodularis?  Yes  No
  3. Has the beneficiary tried and failed, or has contraindication, or intolerance to at least one preferred medium to very high potency topical steroid?  Yes  No
  4. Is Dupixent being prescribed by or in consultation with a dermatologist, allergist, or immunologist?  
 Yes  No
- For continuation of therapy, please answer questions 1-5**
5. 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 Prurigo Nodularis 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 1-800-678-3189

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