WellCare
Beyond Healthcare. A Better You.

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 12 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) or 300 cells/mcL or greater within 12 months prior to use, or sputum eosinophilic count greater than 3%? ☐ **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 of ONE of the following within the past 6 months: Inhaled corticosteroids and long acting beta2 agonist, or Inhaled corticosteroids and long acting muscarinic antagonist? ☐ **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.

Fax this form to **1-800-678-3189.** Pharmacy PA Call Center: **1-866-799-5318**