AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Dupixent: 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. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: ___up to 30 days ___60 days ___90 days ___120 days ___180 days ___365 days ___Other:_____

Clinical Information

1. Is the beneficiary 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 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: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406