NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

WellCare
Beyond Healthcare. A Better You.

Dupixent Temporary PA Request Form

Beneficiary Information

1. Beneficiary Last Name:____________________________ 2. First Name:__________________

3. Beneficiary ID #:_________4. Beneficiary Date of Birth:________ 5. Recipient Gender:_______

Prescriber Information

6. Prescribing Provider NPI#:_____________

7. Requester Contact Information: Name:_______________ Phone #: __________Ext:_________

Drug Information

8. Med requested: **Dupixent** 9a. Strength: ___________ 9b. Quantity per 30 days: _______

9c. Requested Duration: ___________

10. Does the beneficiary have a diagnosis of moderate to severe Atopic Dermatitis? **Yes**_____ **No**_____

11. Has the beneficiary failed at least 2 prescription topical steroids or has a documented adverse reaction or contraindication that precludes trial of at least 2 prescription topical steroids **Yes**_____ **No**_____

List meds tried or reason topical steroids cannot be used:

____

____

12. Has the beneficiary tried and failed on either Protopic, Elidel, or tacrolimus or has a documented adverse reaction or contraindication that precludes trial of either Protopic, Elidel or tacrolimus? **Yes**_____ **No**____

List meds tried or reason Protopic, Elidel, or tacrolimus cannot be used:

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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: **(800) 678-3189** Pharmacy PA Call Center: **(866) 799-5318**