United Healthcare Community Plan

NC Medicaid
Pharmacy Prior Approval Request for
Dupixent: Nasal Polyps

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

Clinical Information

Initial authorization:
1. Is the beneficiary 18 years of age or older? ☐ **Yes** ☐ **No**
3. Does the beneficiary have a diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP)? ☐ **Yes** ☐ **No**
4. Has the beneficiary failed monotherapy with nasal steroids? ☐ **Yes** ☐ **No**
5. Has the beneficiary had treatment for nasal polyps with systemic corticosteroids in the past 2 years, or have contraindications to systemic corticosteroids? ☐ **Yes** ☐ **No Please List tried systemic corticosteroids or contraindications:** _____
_____
6. Will the beneficiary continue to receive intranasal steroid in conjunction with Dupixent? ☐ **Yes** ☐ **No**

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 Nasal Polyps 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 1-866-940-7328

Pharmacy PA Call Center: 1-855-258-1593