

**NC Medicaid and NC Health Choice  
Pharmacy Prior Approval Request for  
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 6 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.