



**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

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.