

North Carolina Department of Health and Human Services
Division of Health Benefits
Dupixent for Nasal Polyps PA Request Form

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. Med requested: **Dupixent** 9a. Strength: _____ 9b. Quantity per 30 days _____

9c. Requested Duration (circle # days): 30 60 90 120 180

10. Is the beneficiary 18 years old or older? Yes _____ No _____

11. Does the beneficiary have a diagnosis of chronic rhinosinusitis with nasal polyposis? Yes ___ No ___

12. Has the beneficiary failed monotherapy with nasal steroids? Yes _____ No _____

List nasal steroids tried or reason nasal steroids cannot be used.

13. Has the beneficiary had previous sino-nasal surgery? Yes ___ No ___

14. Has the beneficiary received treatment for nasal polyps with systemic corticosteroids in the past 2 years?

Yes ___ No ___

List nasal steroids tried or reason nasal steroids cannot be used.

15. Will the beneficiary continue to receive intranasal steroids while receiving Dupixent? Yes ___ No ___

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.

This form can be uploaded into the secure NCTracks Provider Portal, faxed, or mailed to NCTracks. Fax all forms and lab work to NCTracks at: (855) 710-1969. Pharmacy PA Call Center: (866) 246-8505.