DUPIXENT
PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

ONLY the prescriber may complete and fax this form. This form is for prospective, concurrent, and retrospective reviews.

Incomplete forms will be returned for additional information. The following documentation is required for prior authorization consideration. For formulary information and to download additional forms, please visit https://www.bcbstx.com/provider/medicaid/star_kids_prior_auth.html

PATIENT AND INSURANCE INFORMATION **Today's Date:** _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yy):
Patient Address:	City, State, Zip:	Patient Telephone:	
BCBSTX ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis-ICD code plus description:

Medication Requested: Strength:

Dosing Schedule: Quantity per Month:

For All Requests:

1. Is the patient currently treated with the requested medication? ☐ Yes ☐ No
   If yes, when was treatment with the requested medication started? _____
2. Does the patient have a diagnosis of moderate-to-severe atopic dermatitis in the last 365 days? ☐ Yes ☐ No
   If yes, is the affected area greater than or equal to (≥) 10% of the patient's body surface area? ☐ Yes ☐ No
3. Does the patient have a diagnosis of moderate-to-severe asthma in the last 365 days? ☐ Yes ☐ No
   If yes, does the patient have at least a 30-day supply of an oral or inhaled corticosteroid in the last 60 days? ☐ Yes ☐ No
4. Does the patient have a diagnosis of chronic rhinosinusitis with nasal polyposis in the last 365 days? ☐ Yes ☐ No
   If yes, does the patient have at least a 60-day supply of an intranasal corticosteroid in the last 90 days?.. ☐ Yes ☐ No
5. Please list the medications the patient has **previously tried and failed for treatment of this diagnosis** (Please specify if brand name, generic, extended-release products or OTC products)**:**

   _____ Date(s): _____ _____ Date(s): _____
   _____ Date(s): _____ _____ Date(s): _____
   _____ Date(s): _____ _____ Date(s): _____
6. Please list all reasons for selecting the **requested medication** over alternatives (e.g. contraindications, allergies or history of adverse drug reactions.) _____
   _____
7. Please list all other medications the patient is **currently taking** for treatment of this diagnosis. _____
   _____
   _____

For Renewal Requests:

8. Has the patient shown improvement since starting the requested medication? ☐ Yes ☐ No

Prescriber or Authorized Signature: _____ **Date:** _____

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

Please fax or mail this form to:
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Eagan, Minnesota 55121

TOLL FREE

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