

**Dupixent
Prior Authorization Request**

Send completed form to: Case Review Unit CVS Caremark Prior Authorization Fax: 1-866-249-6155

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506**. For inquiries or questions related to the patient's eligibility, drug copy or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

Patient's Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____ **NPI#:** _____
Specialty: _____ **Physician Office Fax:** _____
Physician Office Telephone: _____
Request Initiated For: _____

1. What is the diagnosis?
 Moderate-to-severe atopic dermatitis
 Other _____
2. What is the ICD-10 code? _____
3. Is Dupixent being prescribed by or in consultation with a dermatologist or an allergist/immunologist?
 Yes No
4. Has the patient received Dupixent in a paid claim through a pharmacy or medical benefit in the previous 120 days?
 Yes No *If No, skip to #6*
5. Has the patient achieved or maintained positive clinical response to treatment as evidenced by low disease activity or improvement in signs and symptoms of atopic dermatitis (e.g., redness, itching, oozing/crusting)?
If Yes, no further questions Yes No
6. To which topical therapies, if any, has the patient had an inadequate treatment response in the past 180 days?
Indicate all that apply and no further questions or mark "None of the above."
 Topical corticosteroid
 Topical calcineurin inhibitor (e.g., Elidel, Protopic)
 None of the above
7. Is the use of topical corticosteroids AND topical calcineurin inhibitors not advisable for the patient (e.g., due to contraindications or prior intolerances)? Yes No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X _____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Dupixent SGM - 4/2017.

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