

**NC Medicaid
Pharmacy Prior Approval Request for
Monoclonal Antibodies: Dupixent for Prurigo Nodularis**

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 18 years of age or older? Yes No
2. Does the beneficiary have a diagnosis of Prurigo Nodularis? Yes No
3. Has the beneficiary tried and failed, or has contraindication, or intolerance to at least one preferred medium to very high potency topical steroid? Yes No
4. Is Dupixent being prescribed by or in consultation with a dermatologist, allergist, or immunologist?
 Yes No
For continuation of therapy, please answer questions 1-5
5. 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 Prurigo Nodularis 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.