NC Medicaid and NC Health Choice
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

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**
5. Has the beneficiary had previous sino-nasal surgery? ☐ **Yes** ☐ **No**
6. 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:** ____
   ____
7. Will the beneficiary continue to receive intranasal steroid in conjunction with 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.