Blue Cross® and Blue Shield® of North Carolina (Blue Cross NC) | Healthy Blue® | Healthy Blue® Care Together | Medicaid

Dupixent: Eosinophilic Esophagitis Prior Authorization Form

Member information		
1. Member last name:	2. Member first name:	
3. Member ID #:	4. Member date of birth:	5. Member 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 member 12 years of age or older? ☐ Yes ☐ No		
2. Does the member have a diagnosis of eosinophilic esophagitis? ☐ Yes ☐ No		
3. Has the member tried and failed, or has contraindication, or intolerance to Proton Pump Inhibitors or steroids delivered topically via inhaler, liquid, or tablet? ☐ Yes ☐ No		
For continuation of therapy, please answer questions 1 to 4		
4. While on Dupixent, has the member had continued clinical benefit from baseline supported by medical records? ☐ 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.		

https://provider.healthybluenc.com

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Fax this form to **844-376-2318**
Provider Services: **844-594-5072** (Healthy Blue Provider Services) or **833-777-3698** (Healthy Blue Care Together Provider Services)