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

Dupixent: Prurigo Nodularis 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 18 years of age or older? ☐ Yes ☐ No		
2. Does the member have a diagnosis of prurigo nodularis? ☐ Yes ☐ No		
3. Has the member 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 to 5		
5. While on Dupixent, has the member had continued clinical benefit from baseline supported by medical records? ☐ Yes ☐ No		
Please provide medical records documenting the member's current Prurigo Nodularis status and response to Dupixent treatment		
Signature of prescriber:		Date:

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(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.

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)