Trillium Health Resources
Pharmacy Prior Approval Request for

Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

Monoclonal Antibodies: Dupixent for Nasal Polyps

Member Information

1. Last Name: _____ 2. First Name: _____
3. Trillium ID #: _____ 4. Date of Birth: _____ 5. Gender: _____

Prescriber Information

1. Prescriber Name: _____ 2. NPI #: _____
3. Requestor Name (Nurse/Office Staff): _____
4. Mailing Address: _____ City: _____ State: ____ Zip: _____
5. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

1. Drug Name: **Dupixent** 2. Strength: _____ 3. Quantity per 30 Days: _____
4. Length of Therapy (in Days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days
   ☐ Other _____

Clinical Information

Initial authorization:

1. Is the member 18 years of age or older? ☐ **Yes** ☐ **No**
2. Does the member have a diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP)? ☐ **Yes** ☐ **No**
3. Has the member failed monotherapy with nasal steroids? ☐ **Yes** ☐ **No**
4. Has the member 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**:_____
   _____
5. Will the member continue to receive intranasal steroid in conjunction with Dupixent? ☐ **Yes** ☐ **No**

Continuation of Therapy: (please answer questions 1-6)

6. 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 Nasal Polyps 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.