PACIFIC BLUE CROSS®

DO NOT WRITE IN THIS SPACE

DUPIXENT® INITIAL/RENEWAL REQUEST FORM

⊘ PLEASE DO NOT STAPLE

Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Drop it off: 4250 Canada Way, Burnaby, BC | Fax: 604 419-2689 | Toll-free fax: 1 844 419-2689 | pac.bluecross.ca

HOW TO COMPLETE THIS FORM:
PLAN MEMBERS — Please complete RED portions of this form.
PHYSICIANS — Please complete BLACK portions of this form.

Don't forget to sign *Part 8 — Member Consent and Declaration* before you submit your claim.

The patient is responsible for any fees charged by the physician for completion of this form. These fees are not eligible for reimbursement under your Pacific Blue Cross Extended Health Care plan.

Completion of this form does NOT imply approval for this drug. Coverage is based on the provisions of your Extended Health Care plan and Pacific Blue Cross qualification criteria.

PART 1 — PLAN MEMBER TO COMPLETE

Plan member's name	Patient's name (if different than Plan member's name)			
Patient's birthdate (mm-dd-yyyy)	Policy number	ID number		
Street address	City	Province	Postal code	Daytime phone number (10 digits)

PART 2 — PHYSICIAN TO COMPLETE

Physician's name	College ID		
Street address	City	Province	Postal code

Physician's area of specialty: ☐ Dermatologist ☐ Other: _____

I certify the medical information provided is accurate and current:

Physician's signature X	Date (mm-dd-yyyy)

PART 3 — DRUG REQUESTED

Atopic Dermatitis

Initial Request (please select one and complete part 4, 5, and 7)
☐ Dupilumab (Dupixent®) 600mg initial followed by 300mg every other week
☐ Dupilumab (Dupixent®) 400mg initial followed by 200mg every other week

Renewal (please select one and complete part 6 and 7)
☐ Dupilumab (Dupixent®) 300mg every other week
☐ Dupilumab (Dupixent®) 200mg every other week

Severe Eosinophilic Asthma

Please apply for BC PharmaCare Special Authority if patient resides in BC and send PharmaCare letter of approval to PBC.

PART 4 — PATIENT INFORMATION

☐ Patient has failed to respond, or is intolerant, or is unable to access UV phototherapy
☐ Patient has failed to respond, or is intolerant to medium-potency to high-potency topical corticosteroids
☐ Patient has failed to respond, or is intolerant to topical calcineurin inhibitors
☐ Patient has failed to respond, or experienced a specific intolerance, or has a specific contraindication to one or more systemic agents

	BODY SURFACE AREA (BSA) INVOLVEMENT	PHYSICIAN GLOBAL ASSESSMENT (PGA) SCORE	DATE OF EVALUATION
Baseline pre-treatment	%		(mm-dd-yyyy)

Date of initiation of Dupixent®, if applicable (mm-dd-yyyy): _____

PART 5 — DRUGS CURRENTLY OR PREVIOUSLY PRESCRIBED FOR ATOPIC DERMATITIS

Drug 1	Name	Strength	Dosage	Duration of therapy
If discontinued, please state reason				
Drug 2	Name	Strength	Dosage	Duration of therapy
If discontinued, please state reason				
Drug 3	Name	Strength	Dosage	Duration of therapy
If discontinued, please state reason				
Drug 4	Name	Strength	Dosage	Duration of therapy
If discontinued, please state reason				
Drug 5	Name	Strength	Dosage	Duration of therapy
If discontinued, please state reason				
Drug 6	Name	Strength	Dosage	Duration of therapy
If discontinued, please state reason				

PART 6 — RENEWAL

☐ Patient has responded to therapy

	BODY SURFACE AREA (BSA) INVOLVEMENT	PHYSICIAN GLOBAL ASSESSMENT (PGA) SCORE	DATE OF EVALUATION
Baseline pre-treatment	%		(mm-dd-yyyy)
Current (must be within 90 days of this request)	%		(mm-dd-yyyy)

PART 7 — ADDITIONAL INFORMATION

PART 8 — MEMBER CONSENT AND DECLARATION

IMPORTANT: This section must be signed before submitting your form.

I declare that all information in this form is true and complete. I understand Pacific Blue Cross will use the personal information on this form, and any other personal information they hold about me and my eligible dependents to determine eligibility for benefits and pay claims.

I acknowledge and agree that personal information about me and my eligible dependents may be collected, used and exchanged between Pacific Blue Cross and any other person or organization related to this claim or the administration of my benefit plan. This includes health care professionals, institutions, investigative agencies, insurers/re-insurers, government organizations or regulatory bodies. I acknowledge disclosure of my personal information by Pacific Blue Cross to my plan sponsor when required or permitted by law or pursuant to its contractual obligations under my benefit plan. I understand I may revoke this consent at any time and acknowledge that should I do so, this claim may not be considered.

If there is overpayment, I authorize its recovery from any amount payable to me under my benefit plan(s).

I have read and understand this Member Consent and Declaration and agree that a photocopy or digital version shall be as valid as the original and may remain in effect for the continued administration of this plan. I authorize my physician to release my personal information to Pacific Blue Cross to obtain approval for prescription benefit.

Member's signature	Date (mm-dd-yyyy)
X	