

DUPIXENT (DUPILUMAB)
(PREFERRED)
PRIOR AUTHORIZATION FORM
(form effective 1/8/2024)



Keystone First

PERFORMRxSM
Next Generation Pharmacy Benefits

Fax to PerformRxSM at **1-866-497-1387**, or to speak to a representative, call **1-800-588-6767**.

PRIOR AUTHORIZATION REQUEST INFORMATION

<input type="checkbox"/> New request <input type="checkbox"/> Renewal request	# of pages:	Name of office contact:
Contact's phone number:	LTC facility contact/phone:	

PATIENT INFORMATION

Patient name:	Patient ID #:	DOB:
Street address:	Apt. #:	City/state/zip:

PRESCRIBER INFORMATION

Prescriber name:		
Specialty:	State license #:	NPI:
Street address:	Suite #:	City/state/zip:
Phone:	Fax:	

CLINICAL INFORMATION

Product requested: Dupixent

Strength:	Weight: _____ lbs/kg	Quantity:	Refills: _____
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Directions:

Diagnosis (<i>submit documentation</i>):	Diagnosis code (<i>required</i>):
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PHARMACY INFORMATION (Prescriber to identify the pharmacy that is to dispense the medication):
Deliver to: Patient's Home Physician's Office Patient's Preferred Pharmacy Name:
Pharmacy Phone #: _____ Pharmacy Fax #: _____
 I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.

Is Dupixent being prescribed by or in consultation with a specialist? Yes – *provide specialty*: _____ No

INITIAL REQUESTS

For the treatment of chronic moderate to severe atopic dermatitis: Which of the following treatments have been tried (or cannot be tried due to intolerance or contraindication) by the patient? Check all that apply, and list treatments tried or explain the contraindication or intolerance.

for the face, skin folds, or other critical areas, a 4-week trial of a low-potency (or higher) topical corticosteroid. List treatments tried or explain contraindication: _____

for other body areas, a 4-week trial of a medium potency or higher topical corticosteroid. List treatments tried or explain contraindication: _____

an 8-week trial of a topical calcineurin inhibitor. List treatments tried or explain contraindication: _____

For the treatment of asthma: Indicate which of the following apply to the patient. Check all that apply and submit documentation for each.

has an absolute blood eosinophil count \geq 150 cells/microliter. Eosinophil count: _____ Date of result: _____

is dependent on oral corticosteroids

has asthma that is moderate-to-severe despite use of tolerated asthma controller medications

will use Dupixent in addition to standard asthma controller medications (e.g., inhaled corticosteroids, inhaled LABAs, etc.)

For treatment of eosinophilic esophagitis: Does the patient have a history of therapeutic failure of or a contraindication or intolerance to a proton pump inhibitor?

Yes, list treatments tried or explain contraindication: _____

No, provide explanation: _____

For treatment of prurigo nodularis: Indicate which of the following apply to the patient. Check all that apply and submit documentation for each.

has history of pruritis lasting at least 6 weeks

has prurigo nodularis associated with \geq 20 nodular lesions

has prurigo nodularis associated with significant disability or impairment of physical, mental, or psychosocial functioning

For all other diagnoses: List first-line therapies tried or provide additional justification for use of the requested drug: _____

RENEWAL REQUESTS

Since starting Dupixent, did the patient experience improvement in disease severity? Yes No *Submit documentation of clinical response.*

For asthma, since starting Dupixent, did the patient experience measurable evidence of improvement in the severity of the asthma condition or have a reduction in oral corticosteroid use while maintaining asthma control? Yes No *Submit documentation of clinical response.*

For asthma, will the patient continue to use Dupixent in combination with standard asthma controller medications? Yes No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date:
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