DUPIXENT (DUPILUMAB) (PREFERRED) PRIOR AUTHORIZATION FORM

(form effective 1/8/2024)

Keystone First Community HealthChoices | PERFORMRx℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-855-851-4058**, or to speak to a representative, call **1-866-907-7088**.

PRIOR AUTHORIZATION REQUEST INFORMATION

☐ New request ☐ 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: _____
Directions:			
Diagnosis *(submit documentation)*:			Diagnosis code *(required)*:

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 ≥ 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 ≥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: