DUPIXENT (DUPILUMAB) (PREFERRED) PRIOR AUTHORIZATION FORM





(form effective 1/8/2024)

Fax to PerformRxsM at **1-888-981-5202**, or to speak to a representative, call **1-866-610-2774**.

PRIOR AUTHORIZATION REQU	IEST INFORMAT	ION							
□ 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	e #:			NPI:			
Street address:			Suite	e #:	City/state/zip:				
Phone:				Fax:					
CLINICAL INFORMATION									
Product requested: Dupixent									
Strength:	Weight: lbs	s/kg		Quantity:		ı	Refills:		
Directions:									
Diagnosis (submit documentation):						1	Diagnosis code <u>(required)</u> :		
Pharmacy Phone #:	i's Office Patient'	s Preferred Pha	armacy Na	me: Pharmacy Fa	x #:				
☐ I acknowledge that the patient agrees with							□ No		
	ation with a specialist:	Is Dupixent being prescribed by or in consultation with a specialist? Yes – provide specialty: No							
NITIAL 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. or 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: or other body areas, a 4-week trial of a medium potency or higher topical corticosteroid. List treatments tried or explain contraindication: or other body areas, a 4-week trial of a medium potency or higher topical corticosteroid. List treatments tried or explain contraindication: or the treatment of a topical calcineurin inhibitor. List treatments tried or explain contraindication: or the treatment of asthma: Indicate which of the following apply to the patient. Check all that apply and submit documentation for each. or a dependent on oral corticosteroids or a contraindication or intolerance to a proton pump inhibitor? or treatment of eosinophilic esophagitis: Does the patient have a history of therapeutic failure of or a contraindication or intolerance to a proton pump inhibitor? or treatment of prurigo nodularis: Indicate which of the following apply to the patient. Check all that apply and submit documentation for each. or provide explanation: or pruritis lasting at least 6 weeks or provide additional justification for use of the requested drug: or all other diagnoses: List first-line therapies tried or provide additional justification for use of the requested drug: or all other diagnoses: List fi									
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