DUPIXENT (DUPILUMAB) (NON-PREFERRED) PRIOR AUTHORIZATION FORM

(form effective 1/1/20)

AmeriHealth Caritas Pennsylvania | PERFORMRx℠ Next Generation Pharmacy Benefits

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

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

Will the patient be evaluated, monitored, and treated (if applicable) for helminth infection? ☐ Yes ☐ No

INITIAL REQUESTS

For the treatment of 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 submit documentation for each.

☐ for the face or skin folds, low-potency (or higher) topical corticosteroids. List treatments tried:_____

☐ a topical corticosteroid with a potency appropriate for the patient's age and affected area(s) of the body. List treatments tried:

_____

☐ Elidel (pimecrolimus) or Protopic (tacrolimus). List treatments tried:_____

☐ phototherapy/photochemotherapy (e.g., PUVA, UVB light). List treatments tried:_____

☐ systemic immunosuppressives (e.g., acitretin, cyclosporine, methotrexate, mycophenolate). List treatments tried:_____

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

☐ has a diagnosis of asthma with an eosinophilic phenotype with an absolute blood eosinophil count ≥ 150 cells/microliter. Eosinophil count:_____ Date of result: _____

☐ has a diagnosis of oral corticosteroid-dependent asthma

☐ has asthma that is moderate-to-severe

☐ has tried or cannot use standard asthma controller medications (e.g., inhaled corticosteroids, inhaled long-acting beta agonists (LABAs), etc.)
List treatments tried:_____

☐ has tried or cannot use the preferred MABs for asthma (Fasenra, Nucala, Xolair vial). List preferred MABs tried:_____

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

For a diagnosis other than the approved indication(s), submit documentation supporting the use of the requested medication for the patient's diagnosis and other treatments tried.

RENEWAL REQUESTS

Since starting Dupixent, did the patient experience a positive clinical response and/or improvement in disease severity? ☐ Yes ☐ No *Submit documentation of clinical response.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date: