

**DUPIXENT (DUPILUMAB)
(NON-PREFERRED)
PRIOR AUTHORIZATION FORM**
(form effective 1/1/20)



Keystone First

PERFORMRxSM
Next Generation Pharmacy Benefits

Fax to PerformRxSM at **1-215-937-5018**, 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: _____
Directions:			
Diagnosis (<i>submit documentation</i>):			Diagnosis code (<i>required</i>):
PHARMACY INFORMATION (Prescriber to identify the pharmacy that is to dispense the medication):			
Deliver to: <input type="checkbox"/> Patient's Home <input type="checkbox"/> Physician's Office <input type="checkbox"/> Patient's Preferred Pharmacy Name:			
Pharmacy Phone #:		Pharmacy Fax #:	
<input type="checkbox"/> 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? <input type="checkbox"/> Yes – <i>provide specialty</i> : _____ <input type="checkbox"/> No			
Will the patient be evaluated, monitored, and treated (if applicable) for helminth infection? <input type="checkbox"/> Yes <input type="checkbox"/> 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.			
<input type="checkbox"/> for the face or skin folds, low-potency (or higher) topical corticosteroids. List treatments tried: _____			
<input type="checkbox"/> a topical corticosteroid with a potency appropriate for the patient's age and affected area(s) of the body. List treatments tried: _____			
<input type="checkbox"/> Elidel (pimecrolimus) or Protopic (tacrolimus). List treatments tried: _____			
<input type="checkbox"/> phototherapy/photochemotherapy (e.g., PUVA, UVB light). List treatments tried: _____			
<input type="checkbox"/> 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.			
<input type="checkbox"/> has a diagnosis of asthma with an eosinophilic phenotype with an absolute blood eosinophil count ≥ 150 cells/microliter. Eosinophil count: _____ Date of result: _____			
<input type="checkbox"/> has a diagnosis of oral corticosteroid-dependent asthma			
<input type="checkbox"/> has asthma that is moderate-to-severe			
<input type="checkbox"/> has tried or cannot use standard asthma controller medications (e.g., inhaled corticosteroids, inhaled long-acting beta agonists (LABAs), etc.)			
List treatments tried: _____			
<input type="checkbox"/> has tried or cannot use the preferred MABs for asthma (Fasenra, Nucala, Xolair vial). List preferred MABs tried: _____			
<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit documentation of clinical response.</i>			
PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION			
Prescriber signature:			Date:

Confidentiality Notice: The documents accompanying this telecopy may contain confidential information belonging to the sender. The information is intended only for the use of the individual named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any telecopy is strictly prohibited.