

**DUPIXENT (DUPILUMAB)  
(PREFERRED)  
PRIOR AUTHORIZATION FORM**



# Keystone First

**PERFORMRx**<sup>SM</sup>  
*Next Generation Pharmacy Benefits*

(form effective 1/8/2024)

Fax to PerformRx<sup>SM</sup> at **1-866-497-1387**, or to speak to a representative, call **1-800-588-6767**.

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

<b>PATIENT INFORMATION</b>		
Patient name:	Patient ID #:	DOB:
Street address:	Apt. #:	City/state/zip:

<b>PRESCRIBER INFORMATION</b>		
Prescriber name:		
Specialty:	State license #:	NPI:
Street address:		Suite #:
Phone:		Fax:

**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 ≥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.*

**PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION**

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