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







(form effective 1/8/2024)

Fax to PerformRx<sup>SM</sup> at **1-855-851-4058**, or to speak to a representative, call **1-888-674-8720**.

PRIOR AUTHORIZATION REQU	<b>EST INFORMA</b>	TION						
□ New request □ Renewal request # of pages:				Name of office contact:				
Contact's phone number:	hone 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	e #:	City/state/zip:	,		
Phone:				Fax:				
CLINICAL INFORMATION								
Product requested: Dupixent								
Strength:	Weight: It	bs/kg		Quantity:		F	Refills:	
Directions:								
Diagnosis (submit documentation):						[	Diagnosis code ( <u>required</u> ):	
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 consulta							□ No	
				7				
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:								
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