DUPIXENT (DUPILUMAB) (PREFERRED) PRIOR AUTHORIZATION FORM







(form effective 1/8/2024)

Fax to PerformRxSM at **1-855-851-4058**, or to speak to a representative, call **1-888-674-8720**.

PRIOR AUTHORIZATION REQU	EST INFORMAT	TION					
☐ New request ☐ Renewal request	# of pages:		ne of of	ffice contact:			
Contact's phone number:	ct's phone number: LTC facility contact/phone:						
PATIENT INFORMATION							
Patient name:				Patient ID #:			DOB:
Street address:			Apt. i	#:	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: lb	s/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		•					
	ation with a optionalist.	= 100 provido (ороолал	.,			
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 ≥ 150 cells/microliter. Eosinophil count: Date of result: D							
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