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



KeystoneFirstPERFORMCommunity HealthChoicesNext Generation Pharmacy Benefits

(form effective 1/8/2024)

Fax to PerformRx<sup>™</sup> at **1-855-851-4058**, or to speak to a representative, call **1-866-907-7088**.

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nber:	□ New request □ Renewal request # of pages:			Name of office contact:					
Contact's phone number: LTC facility contact/phone:									
ORMATION									
				Patient ID #:	Patient ID #: DOB:				
Street address: A					City/state/zip:				
INFORMATION									
Specialty: State license #:				NPI:					
Street address: Sui				;#:	City/state/zip:				
Phone:				Fax:					
CLINICAL INFORMATION									
: Dupixent									
	Weight: Ibs/kg			Quantity:			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:									
of the nationt agrees with	the phormony chosen f	or dolivory of this	madia	,	:#:				
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.       Is 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:         in the face, skin folds, or other critical areas, a 4-week trial of a medium potency or higher topical corticosteroid. List treatments tried or explain contraindication:         in an 8-week trial of a topical calcineurin inhibitor. List treatments tried or explain contraindication:         in an 8-week trial of a topical calcineurin inhibitor. List treatments tried or explain contraindication:         in an 8-week trial of a topical calcineurin inhibitor. List treatments tried or explain contraindication:         in an 8-week trial of a topical calcineurin inhibitor. List treatments tried or explain contraindication:         in an 8-week trial of a topical calcineurin inhibitor. List treatments tried or explain contraindication:         in an 8-week trial of a topical calcineurin inhibitor. List treatments tried or explain contraindication:         in an 8-week trial of a topical calcineurin inhibitor. List treatments tried or explain topical contraindication:         in an 8-week trial of a sathma: Indicate which of the following apply to the patient. Check all that apply and submit documentation for each.         has as the treatment of easinophilic explanation:         will us									
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