DUPIXENT (DUPILUMAB) (PREFERRED) PRIOR AUTHORIZATION FORM

(form effective 1/5/2026)

AmeriHealth Caritas Pennsylvania | PERFORMRx℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-888-981-5202**, or to speak to a representative, call **1-866-610-2774**.

PRIOR AUTHORIZATION REQUEST INFORMATION

☐ New request ☐ 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 *(submit documentation)*:			Diagnosis code *(required)*:

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 consultation with a specialist? ☐ Yes – *provide specialty:*_____ ☐ No

INITIAL REQUESTS

For the treatment of chronic atopic dermatitis: Indicate which of the following apply to the patient. Check all that apply and submit documentation for each.
☐ has a BSA ≥ 10% that is affected
☐ has involvement of critical areas of the body (e.g., face, feet, genitals, hands, intertriginous areas, scalp)
☐ has atopic dermatitis that causes significant disability or impaired physical, mental, or psychosocial functioning
☐ for the face, skin folds, or other critical areas, has tried a 4-week trial of a low-potency (or higher) topical corticosteroid. List treatments tried or explain contraindication:
_____
☐ for other body areas, has tried a 4-week trial of medium potency or higher topical corticosteroid. List treatments tried or explain contraindication:
_____
☐ has tried an 8-week trial of a topical calcineurin inhibitor. List treatment 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: _____
☐ 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 bullous pemphigoid: Indicate which of the following apply to the patient. Check all that apply and submit documentation for each.
☐ has tried and failed systemic corticosteroids. List treatments tried or explain contraindication: _____
☐ has corticosteroid-dependent disease
☐ has tried and failed corticosteroid-sparing therapy (e.g., doxycycline, dapsone, methotrexate, mycophenolate, azathioprine). List treatments tried or explain contraindication:
_____

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.*
For asthma, will the patient continue to use Dupixent in combination with standard asthma controller medications? ☐ Yes ☐ No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date: