Trillium Health Resources
Pharmacy Prior Approval Request for

Monoclonal Antibodies: Dupixent for Atopic Dermatitis

Member Information

1. Last Name: _____ 2. First Name: _____
3. Trillium ID #: _____ 4. Date of Birth: _____ 5. Gender: _____

Prescriber Information

1. Prescriber Name: _____ 2. NPI #: _____
3. Requestor Name (Nurse/Office Staff): _____
4. Mailing Address: _____ City: _____ State: ____ Zip: _____
5. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

1. Drug Name: **Dupixent** 2. Strength: _____ 3. Quantity per 30 Days: _____
4. Length of Therapy (in Days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days

Clinical Information

Atopic Dermatitis: (Max Length of Therapy = 180 Days):

1. Is the member 6 years of age or older? ☐ **Yes** ☐ **No**
2. Does the member have a diagnosis of moderate to severe Atopic Dermatitis? ☐ **Yes** ☐ **No**
3. Has the member failed at least two prescription topical steroids? ☐ **Yes** ☐ **No**
   Please List_____
4. Does the member have a documented adverse reaction or contraindication that precludes trial of at least 1 prescription topical steroids? ☐ **Yes** ☐ **No Please List Contraindications:** _____
   _____
5. Does the member have a documented adverse reaction or contraindication that precludes trial of a topical calcineurin inhibitor (e.g., pimecrolimus (ages 2 and older) or tacrolimus 0.03% (ages 2 and older) and 0.1% (ages 18 and older)?☐ **Yes** ☐ **No - Please list Contraindications:** _____
   _____

For continuation of therapy, please answer questions 1-6

6. While on Dupixent, has the member had continued clinical benefit from baseline supported by medical records?
   ☐ **Yes** ☐ **No**

** Please provide medical records documenting the member's clinical benefit from baseline**

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to PerformRx at (833) 726-7628 or call Pharmacy PA Call Center: (855) 662-0277