Trillium Health Resources
Pharmacy Prior Approval Request for

Monoclonal Antibodies: Dupixent for Eosinophilic Esophagitis

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:_____ 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 ☐ 365 Days ☐ Other _____

Clinical Information

1. Is the member age 12 years of age or older? ☐ **Yes** ☐ **No**
2. Does the member have a diagnosis of Eosinophilic Esophagitis? ☐ **Yes** ☐ **No**
3. Has the member tried and failed, or has contraindication, or intolerance to Proton Pump Inhibitors or steroids delivered topically via inhaler, liquid, or tablet? ☐ **Yes** ☐ **No**

For continuation of therapy, please answer questions 1-4

4. 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 current Eosinophilic Esophagitis status and response to Dupixent treatment**

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