**Trillium Health Resources**
**Pharmacy Prior Approval Request for**

# Monoclonal Antibodies: Dupixent for Prurigo Nodularis

**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 18 years of age or older? ☐ **Yes** ☐ **No**
2. Does the member have a diagnosis of Prurigo Nodularis? ☐ **Yes** ☐ **No**
3. Has the member tried and failed, or has contraindication, or intolerance to at least one preferred medium to very high potency topical steroid? ☐ **Yes** ☐ **No**
4. Is Dupixent being prescribed by or in consultation with a dermatologist, allergist, or immunologist? ☐ **Yes** ☐ **No**

**For continuation of therapy, please answer questions 1-5**

5. 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 Prurigo Nodularis 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**