HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM

Atopic Dermatitis: Biologics/JAK Inhibitors

Adbry™, Dupixent®, Rinvoq®

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 888-509-8142.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred/Non-preferred:

1. Preferred
    A. Adbry, Rinvoq
2. Non- preferred
    A. Dupixent®
        i. Adbry or Rinvoq must be tried and failed before Dupixent may be considered, unless documentation indicates a medical necessity.

Product being requested: _____

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Does the member have a diagnosis of moderate to severe atopic dermatitis with at least 10% body surface area (BSA) involvement?	☐	☐	**Please provide documentation**
2. Is the request made by a provider specializing in dermatology, allergy or immunology?	☐	☐	
3. Has the member tried phototherapy?	☐	☐	**Please provide documentation**
4. Has the member had a trial and failure of at least one of the following in the past 6 months: • oral corticosteroid • intramuscular steroid • cyclosporine • azathioprine • methotrexate • mycophenolate	☐	☐	**Please provide documentation**

REAUTHORIZATION			
1. Is the request for reauthorization of atopic dermatitis therapy?	☐	☐	
2. Is there evidence of positive clinical response?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

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Policy: PHARM-135
Origination Date: 05/10/2022
Reviewed/Revised Date: 10/26/2022
Next Review Date:10/26/2023
Current Effective Date: 01/01/2023