## **HEALTHY U** MEDICAID

## PRIOR AUTHORIZATION REQUEST FORM

## **DUPIXENT® for ASTHMA and EOSINOPHILIC ESOPHAGITIS (EoE) and PRURIGO NODULARIS**

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U Prior Authorization Department at 385-425-4052.

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: 385-425-5094

Di	sclaimer: Prior Authorization request for	ms are subject to change in acco	ordance	with Fede	eral and State notice requirements.	
Da	te: Member Name:			ID#:		
DC	OB: Gender:		Physician:			
Office Phone: Office Fax:				Offi	ce Contact:	
He	eight/Weight:					
pr re Pr Do	Tember must try formulary preferred druge ferred products has not been successful as on for failure. Reasons for failure must reduct being requested: □ Dupixent® (duposing/Frequency:  Ote: for the treatment of nasal polypsicatoric dermatitic see Brand Name A	I, you must submit which preferst meet the Health Plan medical upilumab) s see Chronic Rhinosinusitis w	rred prod I necessi	ducts hav ty criterio	e been tried, dates of treatment, and a.	
OT	atopic dermatitis see Brand Name A	topic Dermatitis Agents  for reauthorization, proceed	to real	ıthorizət	tion section	
	Questions	·•	Yes	No	Comments/Notes	
	Questions	ASTHMA	163	140	Comments/Notes	
1.	Does the member have a diagnosis asthma?				Please provide documentation	
2.	<ol><li>Is the request made by, or in consultation with, an allergist, pulmonologist or immunologist?</li></ol>					
3.	3. Has the member had a trial and failure of Fasenra® (benralizumab), unless contraindicated?				Please provide documentation	
4.	Has the member been compliant fo high dose inhaled corticosteroid/lor agonist or with high-dose inhaled coreceptor antagonist?	ng acting inhaled beta-2			Please provide documentation	
5.	Does the member have poor asthm exacerbations that have required enhospitalizations, or frequent office v	mergency department visits,			Please provide documentation	
6.	Does documentation show that the than 80%?	member's FEV1 is less			Please provide documentation	
7.	Are underlying conditions or trigger disease being maximally managed ( irritants – tobacco, allergen exposur	i.e. inhaled respiratory			Please provide documentation	

8. Does the member have a baseline eosinophil count ≥ 300		medications, emotional factors, respiratory infections, COPD,					
cells/µL in the last 6 weeks?  9. Has the member required daily oral corticosteroid therapy for at least the last 6 months?    EOSINOPHILIC ESOPHAGITIS (EOE)	0	etc.)?			Place provide decumentation		
9. Has the member required daily oral corticosteroid therapy for at least the last 6 months?    EOSINOPHILIC ESOPHAGITIS (EOE)	ο.	·		Ш	Please provide documentation		
EOSINOPHILIC ESOPHAGITIS (EOE)  1. Does the member have a confirmed diagnosis of EOE with 15 or more intraepithelial eosinophils per high-power field (eos/hpf) from esophageal biopsy and have symptoms of dysphagia?  2. Is the request made by, or in consultation with, an allergist, or a gastroenterologist?  3. Has the member had a trial and failure of the following:  • Diet modification • Proton-Pump Inhibitor • Topical glucocorticosteroid treatment  4. Does the member weigh more than 40kg?  Please provide documentation  PRURIGO NODULARIS (PN)  1. Is the request made by a provider specializing in dermatology, allergy, or immunology?  2. Is the disease involvement rated as moderate to severe?  3. Has the member tried phototherapy?  4. Has the member tried phototherapy?  5. If unable to tolerate corticosteroids due to the treatment area (e.g. face, genitals, etc.), has the member had an adequate trial with a calcineurin inhibitor such as topical tacrolimus?  6. Has the member tried cyclosporine or methotrexate within the past 6 months?  REAUTHORIZATION	9.	•					
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EOSINOPHILIC ESOPHAGITIS (EoE)	2.				Please provide documentation		
EOSINOPHILIC ESOPHAGITIS (EoE)  1. Is the request for reauthorization of chronic EoE therapy? □ □		documentation demonstrating improvement in eos/hpf from		_	·		
EOSINOPHILIC ESOPHAGITIS (EoE)  1. Is the request for reauthorization of chronic EoE therapy?   2. Is there evidence of positive clinical response as defined by   Please provide documentation		baseline and symptoms?					
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2. Is there evidence of positive clinical response as defined by	2.				Please provide documentation		
documentation demonstrating reduced hospitalization and/or		-					
		emergency room visits?					
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Additional information:						
Physician Signature:						
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\*\* Failure to submit clinical documentation to support this request will result in a dismissal of the request.\*\*

Policy: PHARM-HU-022 Origination Date: 01/01/2022 Reviewed/Revised Date: 03/27/2024 Next Review Date: 03/27/2025 Current Effective Date: 04/01/2024

## **Confidentiality Notice**

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