HEALTHY U MEDICAID

PRIOR AUTHORIZATION REQUEST FORM

Brand Name Atopic Dermatitis Agents

Adbry™, Cibinqo™, Dupixent®, Eucrisa®, Opzelura™, Rinvoq®

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

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.

Product being requested: ☐ Adbry™, ☐ Cibinquo™, ☐ Dupixent® (dupilumab), ☐ Eucrisa®, ☐Opzelura™, ☐Rinvoq®

Dosing/Frequency:_____

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

Questions	Yes	No	Comments/Notes
EUCRISA			
1. Does the member have a diagnosis of mild to moderate atopic dermatitis?	☐	☐	**Please provide documentation**
2. Does documentation show that the member has had an adequate trial and failure of at least one topical corticosteroid?	☐	☐	**Please provide documentation**
3. Does documentation show that the member has had an adequate trial and failure of topical tacrolimus or topical pimecrolimus?	☐	☐	**Please provide documentation**
OPZELURA			
1. Is the request made by a provider specializing in dermatology, allergy, or immunology?	☐	☐	
2. Does documentation show a confirmed diagnosis of mild to moderate atopic dermatitis in a non-immune compromised individual who is not adequately controlled with topical prescription therapies or when these therapies are not advisable?	☐	☐	**Please provide documentation**
3. Is the affected area less than 20% of body surface area?	☐	☐	**Please provide documentation**
4. Does the quantity requested exceed one tube per 30 days?	☐	☐	**Please provide documentation**
5. Has the member had an adequate trial with the following: • a topical calcineurin inhibitor, such as pimecrolimus or tacrolimus,	☐	☐	**Please provide documentation**

• two medium to high potency corticosteroids (e.g., triamcinolone acetonide 0.1%, mometasone furoate 0.1%, betamethasone dipropionate 0.05%, desoximetasone 0.05%), and • phototherapy?			
SYSTEMIC AGENTS			
1. Is the request made by a provider specializing in dermatology, allergy, or immunology?	☐	☐	
2. Has the member had an adequate trial with at least two moderate to very high potency prescription corticosteroids?	☐	☐	**Please provide documentation**
3. 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?	☐	☐	**Please provide documentation**
4. Has the member tried phototherapy?	☐	☐	**Please provide documentation**
5. Has the member had a trial of at least one of the following in the past 6 months: • oral corticosteroid • intramuscular steroid • cyclosporine • azathioprine • methotrexate • mycophenolate	☐	☐	**Please provide documentation**
CIBINQO			
1. Has the member had a 3-month trial and failure of Dupixent and Adbry, unless contraindicated?	☐	☐	**Please provide documentation**
2. Does Clinical documentation show that Tb and Hepatitis Screening have been done?	☐	☐	**Please provide documentation**
RINVOQ			
1. Has the member had a 3-month trial and failure of Adbry, Cibinqo and Dupixent, unless contraindicated?	☐	☐	**Please provide documentation**
2. Does Clinical documentation show that Tb and Hepatitis Screening have been done?	☐	☐	**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:

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

Policy PHARM-HU-135
Origination Date: 04/20/2022
Reviewed/Revised Date: 01/18/2023
Next Review Date: 01/18/2024
Current Effective Date: 02/01/2023