

HEALTHY U CHIP

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 CHIP 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™, Cibinqo™, 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?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
2. Does documentation show that the member has had an adequate trial and failure of at least one topical corticosteroid?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Does documentation show that the member has had an adequate trial and failure of topical tacrolimus or topical pimecrolimus?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
OPZELURA			
1. Is the request made by a provider specializing in dermatology, allergy, or immunology?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Is the affected area less than 20% of body surface area?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Does the quantity requested exceed one tube per 30 days?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. Has the member had an adequate trial with the following: <ul style="list-style-type: none"> a topical calcineurin inhibitor, such as pimecrolimus or tacrolimus, 	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation

<ul style="list-style-type: none"> 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?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member had an adequate trial with at least two moderate to very high potency prescription corticosteroids?	<input type="checkbox"/>	<input type="checkbox"/>	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?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Has the member tried phototherapy?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. Has the member had a trial of at least one of the following in the past 6 months: <ul style="list-style-type: none"> oral corticosteroid intramuscular steroid cyclosporine azathioprine methotrexate mycophenolate 	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
CIBINQO			
1. Has the member had a 3-month trial and failure of Dupixent and Adbry, unless contraindicated?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
2. Does Clinical documentation show that Tb and Hepatitis Screening have been done?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
RINVOQ			
1. Has the member had a 3-month trial and failure of Adbry, Cibinqo and Dupixent, unless contraindicated?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
2. Does Clinical documentation show that Tb and Hepatitis Screening have been done?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
REAUTHORIZATION			
1. Is the request for reauthorization of atopic dermatitis therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is there evidence of positive clinical response?	<input type="checkbox"/>	<input type="checkbox"/>	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-CHIP-135
Origination Date: 07/01/2024
Reviewed/Revised Date:
Next Review Date:
Current Effective Date: 07/01/2024

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