

PRIOR AUTHORIZATION REQUEST FORM

PRURIGO NODULARIS

Dupixent®

For authorization, please answer each question and fax this form PLUS chart notes back to Real Rx 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.

Preferred/Non-Formulary

1. Preferred
 - A. Dupixent® (dupilumab)
2. Non-Formulary
 - A. Nemludio® (nemolizumab-ilto)

Product being requested: _____

Dosing/Frequency: _____

Note: for additional Dupixent indications please see the following:

for treatment of nasal polyps see PHARM-146 Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP), for treatment of atopic dermatitis see PHARM-135 Atopic Dermatitis, for treatment of chronic obstructive pulmonary disease see PHARM-166 Immunomodulators for COPD, for all other indications see PHARM-022

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

Questions	Yes	No	Comments/Notes
1. Is the requesting provider a dermatologist, allergist or immunologist, or in consultation with one?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the disease involvement rated as moderate to severe?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Does the member have at least 20 prurigo nodularis lesions in total on both legs, and/or both arms and/or trunk at time of this request?	<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 an adequate trial with at least one moderate to very high potency prescription corticosteroids?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
6. If unable to tolerate corticosteroids due to the treatment are (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

7. Has the member tried cyclosporine or methotrexate within the past 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is there evidence of a positive clinical response to therapy?	<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:			
PRESCRIBER CERTIFICATION			
I hereby certify this treatment is indicated, necessary and meets the guidelines for use.			
Physician's Signature:			Date:

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Policy: PHARM-160
 Origination Date: 09/11/2024
 Reviewed/Revised Date: 01/14/2026
 Next Review Date: 01/14/2027
 Current Effective Date: 02/01/2026

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