HEALTHY U CHIP

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 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: ☐ Dupixent® (dupilumab)

Dosing/Frequency:_____

Note: for the treatment of nasal polyps see Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP); for the treatment of atopic dermatitis see Brand Name Atopic Dermatitis Agents

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

Questions	Yes	No	Comments/Notes
ASTHMA			
1. Does the member have a diagnosis of moderate to severe asthma?	☐	☐	**Please provide documentation**
2. Is the request made by, or in consultation with, an allergist, pulmonologist or immunologist?	☐	☐	
3. Has the member had a trial and failure of Fasenra® (benralizumab), unless contraindicated?	☐	☐	**Please provide documentation**
4. Has the member been compliant for at least 5 months with high dose inhaled corticosteroid/long acting inhaled beta-2 agonist or with high-dose inhaled corticosteroid/leukotriene receptor antagonist?	☐	☐	**Please provide documentation**
5. Does the member have poor asthma control with recurrent exacerbations that have required emergency department visits, hospitalizations, or frequent office visits?	☐	☐	**Please provide documentation**
6. Does documentation show that the member's FEV1 is less than 80%?	☐	☐	**Please provide documentation**
7. Are underlying conditions or triggers for asthma or pulmonary disease being maximally managed (i.e. inhaled respiratory irritants – tobacco, allergen exposure, physical activity,	☐	☐	**Please provide documentation**

medications, emotional factors, respiratory infections, COPD, etc.)?			
8. Does the member have a baseline eosinophil count ≥ 300 cells/µL in the last 6 weeks?	☐	☐	**Please provide documentation**
9. Has the member required daily oral corticosteroid therapy for at least the last 6 months?			
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?	☐	☐	**Please provide documentation**
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	☐	☐	**Please provide documentation**
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?	☐	☐	**Please provide documentation**
3. Has the member tried phototherapy?	☐	☐	**Please provide documentation**
4. Has the member had an adequate trial with at least two moderate to very high potency prescription corticosteroids?	☐	☐	**Please provide documentation**
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?	☐	☐	**Please provide documentation**
6. Has the member tried cyclosporine or methotrexate within the past 6 months?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
ASTHMA			
1. Is the request for reauthorization for asthma therapy?	☐	☐	
2. Is there evidence of positive clinical response as defined by documentation demonstrating reduced hospitalization and/or emergency room visits?	☐	☐	**Please provide documentation**
EOSINOPHILIC ESOPHAGITIS (EoE)			
1. Is the request for reauthorization of chronic EoE therapy?	☐	☐	
2. Is there evidence of positive clinical response as defined by documentation demonstrating improvement in eos/hpf from baseline and symptoms?	☐	☐	**Please provide documentation**
PRURIGO NODULARIS (PN)			
1. Is the request for reauthorization of prurigo nodularis therapy?	☐	☐	
2. Is there evidence of a positive clinical response to therapy?			**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-CHIP-022
Origination Date: 07/01/2024
Reviewed/Revised Date: 04/09/2025
Next Review Date: 04/09/2026
Current Effective Date: 05/01/2025