HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM

Brand Name Atopic Dermatitis Agents

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

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™, ☐ Cibinquo™, ☐ Dupixent® (dupilumab), ☐ Eucrisa®, ☐Opzelura™, ☐Rinvoq®, ☐Zoryve™ 0.15% cream

Dosing/Frequency:_____

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

Questions	Yes	No	Comments/Notes
MILD TO MODERATE ATOPIC DERMATITIS			
1. Is the request made by, or in consultation with, a provider specializing in dermatology, allergy, or immunology?	☐	☐	
2. Does the member have a diagnosis of mild to moderate atopic dermatitis?	☐	☐	**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?	☐	☐	
5. Has the member had an adequate trial with the following, where appropriate: • a topical calcineurin inhibitor, such as pimecrolimus or tacrolimus, • 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?	☐	☐	**Please provide documentation**
MODERATE TO SEVERE ATOPIC DERMATITIS			
1. Is the request made by a provider specializing in dermatology, allergy, or immunology?	☐	☐	

2. Does the member have a diagnosis of moderate to severe atopic dermatitis with an affected body surface area more than 10%?	☐	☐	**Please provide documentation**
3. Has the member tried at least two moderate to very high potency prescription corticosteroids?	☐	☐	**Please provide documentation**
4. If unable to tolerate corticosteroids due to the treatment area (e.g. face, genitals, etc.), has the member tried a calcineurin inhibitor such as topical tacrolimus?	☐	☐	**Please provide documentation**
5. Has the member tried phototherapy?	☐	☐	**Please provide documentation**
6. Has the member tried at least one of the following in the past 6 months: • oral corticosteroid • intramuscular steroid • cyclosporine • azathioprine • methotrexate • mycophenolate	☐	☐	**Please provide documentation**
7. If the request is for Cibinqo, • has the member had an inadequate response to a 3-month trial of Dupixent and Adbry, and • has Tb and Hepatitis screenings been performed?	☐	☐	**Please provide documentation**
8. If the request is for Rinvoq, • has the member had an inadequate response to a 3-month trial of Dupixent, Adbry and Cibinqo, and • has Tb and Hepatitis screenings been performed?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of atopic dermatitis therapy?	☐	☐	
2. Is there evidence of a 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-CHIP-135
Origination Date: 07/01/2024
Reviewed/Revised Date: 01/29/205
Next Review Date: 01/29/2026
Current Effective Date: 02/01/2025