HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM

Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP)

Dupixent®, Nucala®, Xolair®

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:		HCPCS Code:

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: ☐ Dupixent®(dupilumab), Nucala®(mepolizumab)
Non-preferred: ☐ Xolair®(omalizumab)

Dosing/Frequency:_____

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

Questions	Yes	No	Comments/Notes
DUPIXENT, NUCALA			
1. Does the member have a diagnosis of chronic rhinosinusitis with nasal polyposis confirmed by anterior rhinoscopy, nasal endoscopy, or computed tomography (CT)?	☐	☐	**Please provide documentation**
2. Is the request made by, or in consultation with, an allergist, pulmonologist or ENT specialist?	☐	☐	
3. Has the member had at least a three-month trial and failure of Xhance® (fluticasone) nasal spray, which requires prior authorization, in addition to saline lavage?	☐	☐	**Please provide documentation**
4. Has the member tried and failed at least two weeks of systemic corticosteroid therapy?	☐	☐	**Please provide documentation**
5. Has the member tried and failed at least two weeks of doxycycline or macrolide antibiotics?	☐	☐	**Please provide documentation**
6. Will the requested therapy be used in combination with an intranasal corticosteroid?	☐	☐	
XOLAIR			
1. Does the documentation include the current body weight and baseline serum IgE?	☐	☐	**Please provide documentation**

REAUTHORIZATION			
1. Is the request for reauthorization of chronic rhinosinusitis therapy?	☐	☐	
2. Has the member experienced a reduction in their nasal congestion and nasal polyp size?	☐	☐	
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-146
Origination Date: 07/01/2024
Reviewed/Revised Date: 08/29/2024
Next Review Date: 08/29/2025
Current Effective Date: 09/01/2024