HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM CHRONIC SPONTANEOUS URTICARIA

Dupixent[®], Xolair[®]

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department.

- For Medical Pharmacy please fax requests to: 801-213-1547
- For Retail Pharmacy please fax requests to: 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 Pharmacy Customer Service for assistance at 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/Non-Preferred

- 1. Preferred
 - a. Xolair[®] (omalizumab)
- 2. Non-Preferred
 - a. Dupixent[®] (dupilumab)

Dosing/Frequency:_

Note: for the treatment of nasal polyps see Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP)

If the request is for reauthorization, proceed to reauthorization section					
Questions		Yes	No	Comments/Notes	
1.	Has the provider performed a medical evaluation that rules out			Please provide documentation	
	other possible causes of urticaria?				
2.	Has the member had a trial and failure of an H1-antihistamine at			Please provide documentation	
	up to four times standard dosing used in combination with an				
	H2-antihistamine?				
3.	Has the member had a trial and failure of an H1-antihistamine	\boxtimes		Please provide documentation	
	used in combination with a leukotriene receptor antagonist or				
	cyclosporine?				
4.	Is the request for dose escalation of Xolair [®] ?				
5.	For Dupixent [®] , does the member have a contraindication or			Please provide documentation	
	intolerance to Xolair [®] ?				
REAUTHORIZATION					
1.	Is the request for reauthorization of therapy?				

2.	Does clinical documentation show continued medical necessity			Please provide documentation			
	and that the treatment has stabilized or improved the member's						
	condition?						
Wh	at medications and/or treatment modalities have been tried in th	ne past	for this	condition? Please document			
name of treatment, reason for failure, treatment dates, etc.							
The of treatment, reason for failure, treatment dates, etc.							
Add	litional information:						
Physician's Signature:							
-	-						

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Policy: PHARM-CHIP-164 Origination Date: 06/11/2025 Reviewed/Revised Date: 06/11/2025 Next Review Date: 06/11/2026 Current Effective Date: 07/01/2025

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