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 other possible causes of urticaria?	☐	☐	**Please provide documentation**
2. Has the member had a trial and failure of an H1-antihistamine at up to four times standard dosing used in combination with an H2-antihistamine?	☐	☐	**Please provide documentation**
3. Has the member had a trial and failure of an H1-antihistamine used in combination with a leukotriene receptor antagonist or cyclosporine?	☒	☐	**Please provide documentation**
4. Is the request for dose escalation of Xolair®?	☐	☐	
5. For Dupixent®, does the member have a contraindication or intolerance to Xolair®?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	

2. Does clinical documentation show continued medical necessity and that the treatment has stabilized or improved the member's condition?	☐	☐	**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's Signature:			

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Policy: PHARM-CHIP-164
Origination Date: 06/11/2025
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