

# HEALTHY U CHIP

## PRIOR AUTHORIZATION REQUEST FORM IMMUNOMODULATORS FOR COPD

Dupixent<sup>®</sup>, Ohtuvayre<sup>™</sup>

**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.**

**Product being requested:**  Dupixent<sup>®</sup> (dupilumab),  Ohtuvayre<sup>™</sup> (ensifentrine)

Dosing/Frequency: \_\_\_\_\_

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

Questions	Yes	No	Comments/Notes
1. Is the request made by, or in consultation with, a pulmonologist?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does the member has a diagnosis of moderate to severe Chronic Obstructive Pulmonary Disease (COPD) confirmed by an FEV <sub>1</sub> /FVC ratio of <0.7 AND a post-bronchodilator FEV <sub>1</sub> of 30-70% predicted?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has the member had at least 2 exacerbations in the past 12 months requiring treatment (i.e. steroids, antibiotics) OR at least 1 exacerbation in the past 12 months requiring hospitalization?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Will maintenance therapy be continued with the requested therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Has the member been stable on triple-therapy (long-acting beta-2 agonist [LABA]/long-acting muscarinic antagonist [LAMA]/inhaled corticosteroid [ICS]) for at least 3 months?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. For Dupixent <sup>®</sup> , does the member have an eosinophil count of 300 cells/microliters or more?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. For Ohtuvayre <sup>™</sup> , has the member been stable on dual-therapy (LABA/LAMA) and has an eosinophil count of less than 100 cells/microliter?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

### REAUTHORIZATION

1. Is the request for reauthorization?	<input type="checkbox"/>	<input type="checkbox"/>	
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2. Has the member had a positive clinical response (i.e. reduced symptoms, reduced exacerbations, reduced hospitalizations, reduced emergency department or urgent care visits, improved lung function)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Will the member continue taking maintenance therapy (LABA/LAMA/ICS or LABA/LAMA)?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>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.</b>			
Additional information:			
Physician's Signature:			

**\*\* Failure to submit clinical documentation to support this request will result in a dismissal of the request.\*\***

Policy: PHARM-CHIP-166  
 Origination Date: 07/25/2025  
 Reviewed/Revised Date:  
 Next Review Date: 07/25/2026  
 Current Effective Date: 08/01/2025

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