PRIOR AUTHORIZATION REQUEST FORM

Biologic Medications for Asthma

Cinqair®, Dupixent®, Exdensur, Fasenra®, Nucala®, Tezspire®, 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: ☐ Fasenra® (benralizumab), ☐ Xolair® (omalizumab)
Non-Preferred: ☐ Cinqair® (reslizumab), ☐ Dupixent® (dupilumab), ☐ Exdensur (depemokimab) ☐ Nucala® (mepolizumab), ☐ Tezspire™ (tezepelumab-ekko)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is the prescribing provider an allergist, dermatologist, immunologist, or pulmonologist?	☐	☐	
2. Has the member been ≥80% compliant with a high-dose inhaled corticosteroid (ICS)/long-acting inhaled beta-2-agonist (LABA) inhaler for at least the past 6 months?	☐	☐	**Please provide documentation**
3. Will the requested medication be used in combination with an ICS/LABA inhaler?	☐	☐	
4. Does the member have poor asthma control, defined as both of the following: • two or more acute exacerbations in the past 12 months requiring additional medical treatment • Poor asthma control shown by an Asthma Control Questionnaires (ACQ) score or an Asthma Control Test (ACT)	☐	☐	**Please provide documentation**
5. Is the member an active smoker? If yes, does documentation show that smoking cessation has been addressed?	☐	☐	**Please provide documentation**
Xolair®			
1. Has the member shown a positive skin test or in vitro reactivity to a perennial aeroallergen?	☐	☐	**Please provide documentation**

2. Are the member's pre-treatment serum IgE levels ≥30 IU/mL and ≤700 IU/mL?	☐	☐	**Please provide documentation**
Fasenra®, Nucala®, Cinqair®, Exdensur			
1. Does documentation show the member's baseline eosinophil count?	☐	☐	**Please provide documentation**
2. For Nucala®, Cinqair®, and Exdensur, has the member tried and failed Fasenra®?	☐	☐	**Please provide documentation**
Tezspire™			
1. Has the member tried and failed Fasenra®?	☐	☐	**Please provide documentation**
Dupixent®			
1. Does the member have a baseline eosinophil count ≥ 300 cell/µL in the last 6 weeks?	☐	☐	**Please provide documentation**
2. Has the member required daily oral corticosteroid therapy for at least the last 6 months?	☐	☐	**Please provide documentation**
3. Has the member tried and failed Fasenra®?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization?	☐	☐	
2. Does updated documentation show a positive clinical response to therapy (reduced number of exacerbations, improved FEV1, reduced severity or number of asthma-related symptoms)?	☐	☐	**Please provide documentation**
3. Has the member been and will continue to be adherent to ICS/LABA inhalers at least 80% of the time?	☐	☐	

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:

PRESCRIBER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

Physician's Signature:	Date:

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

Policy: PHARM-CHIP-194
Origination Date: 07/01/2024
Reviewed/Revised Date: 04/08/2026
Next Review Date: 04/08/2027
Current Effective Date: 05/01/2026

Confidentiality Notice

This document and any accompanying document contain confidential information and is intended for the use of the individual or entity named on this transmission sheet. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this information is strictly prohibited and the document should be returned to this office immediately. If you have received this facsimile in error, please notify us by telephone immediately and destroy document received.