

# HEALTHY U MEDICAID

## 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 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
<b>DUPIXENT, NUCALA</b>			
1. Does the member have a diagnosis of chronic rhinosinusitis with nasal polyposis confirmed by anterior rhinoscopy, nasal endoscopy, or computed tomography (CT)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the request made by, or in consultation with, an allergist, pulmonologist or ENT specialist?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Has the member tried and failed at least two weeks of systemic corticosteroid therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Has the member tried and failed at least two weeks of doxycycline or macrolide antibiotics?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Will the requested therapy be used in combination with an intranasal corticosteroid?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>XOLAIR</b>			
1. Does the documentation include the current body weight and baseline serum IgE?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

REAUTHORIZATION			
1. Is the request for reauthorization of chronic rhinosinusitis therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member experienced a reduction in their nasal congestion and nasal polyp size?	<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 Signature:			

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

Policy PHARM-HU-146  
 Origination Date: 10/27/2022  
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