HEALTHY U MEDICAID

PRIOR AUTHORIZATION REQUEST FORM

PRURIGO NODULARIS

Dupixent®

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:		

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-Formulary

1. Preferred
   A. Dupixent® (dupilumab)
2. Non-Formulary
   A. Nemluvio® (nemolizumab-ilto)

Product being requested:_____

Dosing/Frequency:_____

Note: for additional Dupixent indications please see the following:
for treatment of nasal polyps see PHARM-HU-146 Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP), for treatment of atopic dermatitis see PHARM-HU-135 Atopic Dermatitis, for all other indications see PHARM-HU-022

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

Questions	Yes	No	Comments/Notes
1. Is the requesting provider a dermatologist, allergist or immunologist, or in consultation with one?	☐	☐	
2. Is the disease involvement rated as moderate to severe?	☐	☐	**Please provide documentation**
3. Does the member have at least 20 prurigo nodularis lesions in total on both legs, and/or both arms and/or trunk at time of this request?	☐	☐	**Please provide documentation**
4. Has the member tried phototherapy?	☐	☐	**Please provide documentation**
5. Has the member had an adequate trial with at least two moderate to very high potency prescription corticosteroids?	☐	☐	**Please provide documentation**
6. If unable to tolerate corticosteroids due to the treatment are (e.g. face, genitals, etc.), has the member had an adequate trial with a calcineurin inhibitor such as topical tacrolimus?	☐	☐	**Please provide documentation**

7. Has the member tried cyclosporine or methotrexate within the past 6 months?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Is there evidence of a positive clinical response to therapy?	☐	☐	**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 Signature:

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

Policy: PHARM-HU-160
Origination Date: 09/11/2024
Reviewed/Revised Date: 09/18/2024
Next Review Date: 09/18/2025
Current Effective Date: 10/01/2024