

## PRIOR AUTHORIZATION REQUEST FORM

### Monoclonal Antibodies for Atopic Dermatitis

Adbry, Dupixent, Ebglyss, Nemluvio

**For authorization, please answer each question and fax this form PLUS chart notes back to RealRx Medicaid 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 Pharmacy Customer Service for assistance.

- Healthy U: 855-856-5694
- Healthy U CHIP: 855-203-3633
- Health Choice Utah: 855-864-1404

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:

**Preferred Products:** Adbry, Dupixent, Opzelura\*\*, pimecrolimus, Rinvoq\*\*\*, tacrolimus

**Non-preferred Products:** Anzupgo\*, Cibinqo\*, Ebglyss, Eucrisa\*, Hyftor\*, Nemluvio, Vtama\*, Zoryve\*

\*See the Atopic Dermatitis prior authorization form for criteria

\*\* See the Opzeulra prior authorization form for criteria

\*\*\* See the Rinvoq prior authorization form for criteria

Product Requested: \_\_\_\_\_

Directions for Use: \_\_\_\_\_

<b>Criteria for Approval: (All of the following criteria must be met)</b>	<b>Yes</b>	<b>No</b>
1. Does the patient have a documented diagnosis of moderate to severe atopic dermatitis with involvement estimated to be greater or equal to 10% of the body surface area (BSA), <b>OR</b> less than 10% of BSA with atopic dermatitis involvement to face, eyes/eyelids, skin folds, and/or genitalia?	<input type="checkbox"/>	<input type="checkbox"/>
2. Is the medication being prescribed by or in consultation with a dermatologist, allergist, immunologist, or provider specializing in the disease treatment?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the member tried and failed at least one medium- to super-high-potency topical corticosteroid (TCS) AND a topical calcineurin inhibitor (TCI) at a minimum of 4 weeks? (If involvement to the face, eyes/eyelids, skin folds, and/or genitalia, trial and failure of TCS is not required)	<input type="checkbox"/>	<input type="checkbox"/>
TCS Medication: _____ Date of therapy: _____		
Details of Failure: _____		
TCI Medication: _____ Date of therapy: _____		
Details of Failure: _____		
4. Does the provider attest the patient will <b>NOT</b> have concurrent use with another biologic immunomodulator, JAK inhibitor, or PDE4-inhibitor?	<input type="checkbox"/>	<input type="checkbox"/>
5. Does the provider attest to prescribing the appropriate dose based on indication and patient's weight?	<input type="checkbox"/>	<input type="checkbox"/>

<input type="checkbox"/> Weight: _____		
6. Does the patient meet the minimum age requirements based on FDA approved indication of the medication?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Non-preferred Criteria for Approval: (At least ONE of the following criteria must be</b>		
1. Has the patient tried and failed at least one preferred agent within the same PDL class at an appropriate dose and duration?  Medication and Dose: _____ Details of Failure: _____	<input type="checkbox"/>	<input type="checkbox"/>
2. Has the provider submitted appropriate clinical rationale for prescribing the non-preferred product over a preferred option within the same PDL class?  Rationale: _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Reauthorization</b>		
1. Has the provider submitted an updated letter of medical necessity or updated chart notes demonstrating the patient has had a positive clinical response, including reduced BSA involvement and improvement in symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the provider attest the patient does <b>NOT</b> have concurrent use with another biologic immunomodulator, JAK inhibitor, or PDE4-inhibitor?	<input type="checkbox"/>	<input type="checkbox"/>
<b>PRESCRIBER CERTIFICATION</b>		
I hereby certify this treatment is indicated, necessary and meets the guidelines for use.		
Physician's Signature:	Date:	

**Initial Authorization:** Up to six (6) months

**Reauthorization:** Up to one (1) year

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

Policy: PHARM-HYB-179

Origination Date: 01/01/2026

Reviewed/Revised Date:

Next Review Date:

Current Effective Date: 01/01/2026

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