UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Monoclonal Antibodies for Atopic Dermatitis (Adbry, Dupixent, Ebglyss, Nemluvio)

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/ Strength:	
☐ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.	
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*Requesting Prescriber NPI:
Address:	
*Contact Person:	*Office Phone:
*Office Fax:	*Office Email:
Medically Billed Information * indicates required field for all medically billed products	
*Diagnosis Code:	*HCPCS Code:
*Dosing Frequency:	*HCPCS Units per Dose:
Servicing Provider Name:	NPI:
Servicing Provider Address:	
Facility/Clinic Name:	NPI:
Facility/Clinic Address:	
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

***For asthma and other indications for Dupixent, see Monoclonal Antibodies for Asthma and Other Indication PA**

Criteria for Approval: (*All* of the following criteria must be met)

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), **OR** less than 10% of BSA with atopic dermatitis involvement to face, eyes/eyelids, skin folds, and/or genitalia? ❑ **Yes** ❑ **No**
2. Is the medication being prescribed by or in consultation with a dermatologist, allergist, immunologist, or provider specializing in the disease treatment? ❑ **Yes** ❑ **No**
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? ❑ **Yes** ❑ **No**
   TCS Medication: _____ Date of therapy: _____
   Details of Failure: _____
   TCI Medication: _____ Date of therapy: _____
   Details of Failure: _____
4. Does the provider attest the patient will **NOT** have concurrent use with another biologic immunomodulator, JAK inhibitor, or PDE4-inhibitor? ❑ **Yes** ❑ **No**

5. Does the provider attest to prescribing the appropriate dose based on indication and patient's weight?
   ☐ Weight: _____ ❑ **Yes** ❑ **No**
6. Does the patient meet the minimum age requirements based on FDA approved indication of the medication? ❑ **Yes** ❑ **No**

Non-preferred Criteria for Approval: (*At least ONE* of the following criteria must be met)

1. Has the patient tried and failed at least one preferred agent within the same PDL class at an appropriate dose and duration? ❑ **Yes** ❑ **No**
   Medication and Dose: _____ Details of Failure: _____
2. Has the provider submitted appropriate clinical rationale for prescribing the non-preferred product over a preferred option within the same PDL class? ❑ **Yes** ❑ **No**
   Rationale: _____

Reauthorization Criteria:

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? ❑ **Yes** ❑ **No**
2. Does the provider attest the patient does **NOT** have concurrent use with another biologic immunomodulator, JAK inhibitor, or PDE4-inhibitor? ❑ **Yes** ❑ **No**

Initial Authorization: Up to six (6) months
Reauthorization: Up to one (1) year

PROVIDER CERTIFICATION

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

_____ _____

Prescriber's Signature Date