



PRIOR AUTHORIZATION REQUEST

EOHILIA

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number:	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength:	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for ALL PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1 Is this request for initial therapy or for a continuation of therapy?

Initial (If checked, go to 9)

Continuation (If checked, go to 2)

2 Is the patient currently receiving the requested medication? Yes No

[If no, skip to question 9.]

**If you have any
questions, call:
1-888-258-8250**

Version 04.2026

PRIOR AUTHORIZATION REQUEST

3	Has the patient been receiving medication samples of the requested medication? [If yes, skip to question 9.]	Yes	No
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 9.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If yes, no further questions.]	Yes	No
6	Has the patient been treated previously with a 12-week course of the requested medication? [If yes, no further questions.]	Yes	No
7	Has documentation been provided to confirm that the patient is currently receiving a course of the requested medication and additional medication is needed to complete a 12-week course of treatment? If yes, please list how many weeks of the current course the patient has received of the requested medication: _____ . ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
[NOTE: The maximum recommended treatment is for 12 weeks. For a patient who has started therapy but has not completed 12 weeks, the approval end date should be the number of weeks remaining to allow a total of 12 weeks of treatment.]			
8	Has documentation been submitted to confirm that the patient has had a significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
[NOTE: The maximum recommended treatment is for 12 weeks. For a patient who has started therapy but has not completed 12 weeks, the approval end date should be the number of weeks remaining to allow a total of 12 weeks of treatment.]			
9	What is the diagnosis or indication? <input type="checkbox"/> Eosinophilic esophagitis (If checked, go to 10) <input type="checkbox"/> Other (If checked, no further questions)		
10	Is the patient greater than or equal to 11 years of age? [If no, no further questions.]	Yes	No

**If you have any
questions, call:
1-888-258-8250**

Version 04.2026

PRIOR AUTHORIZATION REQUEST

- | | | | |
|----|--|-----|----|
| 11 | Does the patient have a diagnosis of eosinophilic esophagitis as confirmed by an endoscopic biopsy demonstrating greater than or equal to 15 intraepithelial eosinophils per high-power field?
[If no, no further questions.] | Yes | No |
| 12 | Does the patient have dysphagia on at least 4 days in any 2 consecutive weeks measured by the Dysphagia Symptom Questionnaire (DSQ)?
[If no, no further questions.] | Yes | No |
| 13 | Has documentation been provided to confirm that the patient has a trial and failure with a proton pump inhibitor (received at least 8 weeks of therapy at maximal doses) or has a documented intolerance or contraindication? Examples of proton pump inhibitors are omeprazole, esomeprazole, pantoprazole, etc. ACTION REQUIRED: Submit supporting documentation.
[If no, no further questions.] | Yes | No |
| 14 | Has the patient tried dietary modifications to manage eosinophilic esophagitis?
[NOTE: Examples of dietary modifications to treat eosinophilic esophagitis include an elemental diet or an elimination diet.]
[If yes, skip to question 16.] | Yes | No |
| 15 | Has the provider determined that the patient is not an appropriate candidate for dietary modifications?
[If no, no further questions.] | Yes | No |
| 16 | Does the provider attest that the patient will be monitored for infection?
[If no, no further questions.] | Yes | No |
| 17 | Will the requested medication be used concurrently with Dupixent (dupilumab)?
[If yes, no further questions.] | Yes | No |
| 18 | Is the patient currently receiving the requested medication?
[If no, skip to question 20.] | Yes | No |
| 19 | Has documentation been provided to confirm that the patient is currently receiving a course of the requested medication and additional medication is needed to complete a 12-week course of treatment? If yes, please list how many weeks of the current course the patient has received of the requested medication:
_____ . ACTION REQUIRED: Submit supporting documentation.
[If no, no further questions.] | Yes | No |

[NOTE: The maximum recommended treatment is for 12 weeks. For a patient who has started therapy but has not completed 12 weeks, the approval end date should be the number of weeks remaining to allow a total of 12 weeks of treatment.]

**If you have any
questions, call:
1-888-258-8250**

Version 04.2026



PRIOR AUTHORIZATION REQUEST

20	Is the requested medication being prescribed by or in consultation with an allergist or gastroenterologist? [If no, no further questions.]	Yes	No
21	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the requested indication? Note: Dosing is 2 mg orally twice daily for 12 weeks.	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

**If you have any questions, call:
1-888-258-8250**

Version 04.2026