SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Opzelura™ (ruxolitinib) **(Non-Preferred)**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

Quantity Limit: 240 grams per 30 days

Other Indications: Opzelura cream will not be approved for the indication of nonsegmental vitiligo in adult and pediatric patients ≥ 12 years old

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Length of Authorization: 1 year

- ❑ Member must be 12 years of age or older and have an FDA-approved diagnosis for mild to moderate Atopic Dermatitis

(Continued on next page)

- ❑ Prior documented trial and failure of 8 weeks for each trial (or contraindication) of:
  - ❑ One (1) topical corticosteroid of medium to high potency (e.g., mometasone, triamcinolone)
  - ❑ One (1) topical calcineurin inhibitors (tacrolimus or pimecrolimus)
  - ❑ Trial and failure of Dupixent®

Medication being provided by Specialty Pharmacy - PropriumRx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*

REVISED/UPDATED/REFORMATTED: ~~12/7/2021; 1/10/2022; 6/29/2022; 12/27/2022; 12/20/2023, 12/3/2024; 12/9/2024;~~ **3/25/2025**