

# 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  $\geq 12$  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 2 years of age or older and have an FDA-approved diagnosis for mild to moderate Atopic Dermatitis

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- ☐ 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.\****