SENTARA HEALTH PLANS

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: Leqselvi™ (deuruxolitinib)

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: 60 tablets per 30 days

NOTE: The Health Plan considers the use of concomitant therapy with more than one biologic immunomodulator (e.g., Dupixent, Olumiant, Xeljanz IR/XR) prescribed for the same or different indications to be experimental and investigational. Safety and efficacy of these combinations has **NOT** been established and will **NOT** be permitted.

- Will the member be discontinuing a previously prescribed biologic if approved for requested medication?

  ❑ Yes **OR** ❑ No

- If yes, please list the medication that will be discontinued and the medication that will be initiated upon approval along with the corresponding effective date.

  Medication to be discontinued: _____ **Effective date:** _____

  Medication to be initiated: _____ **Effective date:** _____

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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.

- ❑ Member is 18 years of age or older
- ❑ Prescribed by or in consultation with a **Dermatologist**
- ❑ Member has a diagnosis of **alopecia areata**
- ❑ Member has ≥ 50% of scalp hair loss measured by the Severity of Alopecia Tool (SALT) for more than 6 months **(chart notes with documentation of SALT score must be submitted)**
- ❑ Member does **NOT** have hair loss due to other forms of alopecia (i.e., androgenetic alopecia, chemotherapy induced, trichotillomania, telogen effluviums, and systemic lupus erythematosus)
- ❑ Member has experienced treatment failure, has a contraindication or intolerance to **ONE** of the following therapies used for at least **three (3) months (chart notes documenting treatment failure must be submitted)**:
  - ❑ Oral corticosteroids (e.g., prednisone)
  - ❑ Oral immunosuppressants (e.g., azathioprine, cyclosporine, methotrexate)
  - ❑ Intralesional corticosteroids (e.g., triamcinolone acetonide 5-10 mg/mL)
  - ❑ Topical immunotherapy treatment (e.g., Squaric Acid Dibutyl Ester – SADBE; Diphenylcyclopropenone – DPCP)
- ❑ Member is **NOT** receiving Leqselvi in combination with other JAK inhibitors, biologic immunomodulators, or with other potent immunosuppressants

Medication being provided by Specialty Pharmacy – Proprium Rx

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.*