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 information provided is not complete, correct, or legible, authorization may be delayed.**

Drug Requested: Opzelura™ (ruxolitinib)

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 Form/Strength: _____

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

Diagnosis: _____ **ICD Code:** _____

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

Quantity Limits: 1 tube (60 grams) per 28 days

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.

Diagnosis: Mild to Moderate Atopic Dermatitis

Initial Authorization: 6 months

- ❑ Prescribed by or in consultation with an allergist, dermatologist, or immunologist
- ❑ Member is 2 years of age or older
- ❑ Member is **NOT** immunocompromised
- ❑ Medication will **NOT** be used in combination with other biologic disease-modifying antirheumatic drugs (e.g., Humira, Enbrel, Taltz, Stelara), JAK inhibitors (e.g., Xeljanz, Rinvoq, Olumiant), or potent immunosuppressants (e.g., azathioprine, cyclosporine)

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- ❑ Member will **NOT** be applying to more than 20% of Body Surface Area (BSA) **(Chart notes documenting BSA must be attached)**
- ❑ Member has a **history of failure, contraindication, or intolerance** to **ALL** the following therapies **(chart notes documenting contraindication(s) or intolerance must be attached; trials will be verified using pharmacy claims and/or submitted chart notes)**:
  - ❑ 30 days (14 days for very high potency) of therapy with **TWO** topical corticosteroids in the past 180 days
  - ❑ 30 days of therapy with **ONE** of the following topical calcineurin inhibitors in the past 180 days:
    - ❑ tacrolimus (Protopic) 0.1% or 0.03% ointment
    - ❑ pimecrolimus (Elidel) 1% cream (***requires prior authorization*)**
  - ❑ 30 days of therapy with Eucrisa (crisaborole) 2% ointment in the past 180 days **(*requires prior authorization*)**

Reauthorization: 12 months. 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.

- ❑ Documentation of positive clinical response to therapy (e.g., reduced BSA involvement, severity, itch) **(Chart notes must be submitted)**
- ❑ Medication will **NOT** be prescribed concurrently with biologic disease-modifying antirheumatic drugs (e.g., Humira, Enbrel, Taltz, Stelara), JAK inhibitors (e.g., Xeljanz, Rinvoq, Olumiant), or potent immunosuppressants (e.g., azathioprine, cyclosporine)
- ❑ Member has **NOT** experienced serious treatment-related adverse events (e.g., serious infections, lymphoma or other malignancies, non-melanoma skin cancer, major adverse cardiovascular events (MACE), thrombosis, thrombocytopenia, anemia, neutropenia, or lipid elevations)

Diagnosis: Vitiligo

Initial Authorization: 6 months

- ❑ Prescribed by or in consultation with a dermatologist
- ❑ Member has a diagnosis of non-segmental vitiligo
- ❑ Member is 12 years of age or older
- ❑ Medication will **NOT** be used in combination with other biologic disease-modifying antirheumatic drugs (e.g., Humira, Enbrel, Taltz, Stelara), JAK inhibitors (e.g., Xeljanz, Rinvoq, Olumiant), or potent immunosuppressants (e.g., azathioprine, cyclosporine)
- ❑ Provider attests the area impacted by vitiligo does **NOT** exceed 10% of the member's Body Surface Area (BSA) **(Chart notes documenting BSA must be attached)**

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- ❑ Member has a **history of failure, contraindication, or intolerance** to **ALL** the following therapies **(chart notes documenting contraindication(s) or intolerance must be attached; trials will be verified using pharmacy claims and/or submitted chart notes)**:
  - ❑ 90 days of therapy with **ONE** high to very high potency topical corticosteroid unless the member has lesions located on sensitive areas (i.e., face, anogenital area or skin folds)
  - ❑ 90 days of therapy with **ONE** of the following topical calcineurin inhibitors:
    - ❑ tacrolimus (Protopic) 0.1% or 0.03% ointment
    - ❑ pimecrolimus (Elidel) 1% cream (***requires prior authorization*)**
  - ❑ 90 days of phototherapy (UVB or PUVA)

Reauthorization: 12 months. 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.

- ❑ Documentation of positive clinical response to therapy (e.g., re-pigmentation) **(Chart notes must be submitted)**
- ❑ Medication will **NOT** be prescribed concurrently with biologic disease-modifying antirheumatic drugs (e.g., Humira, Enbrel, Taltz, Stelara), JAK inhibitors (e.g., Xeljanz, Rinvoq, Olumiant), or potent immunosuppressants (e.g., azathioprine, cyclosporine)
- ❑ Member has **NOT** experienced serious treatment-related adverse events (e.g., serious infections, lymphoma or other malignancies, non-melanoma skin cancer, major adverse cardiovascular events (MACE), thrombosis, thrombocytopenia, anemia, neutropenia, or lipid elevations)

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.****