



Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.  
Opzelura (ruxolitinib) Prior Authorization (PA)  
Pharmacy Benefits Prior Authorization Help Desk  
Length of Authorizations: Initial- 6 months; Continuation- 12 months

**Instructions:**

This form is used by Kaiser Permanente and/or participating providers for coverage of **Opzelura (ruxolitinib)**. Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours (fax: 1-866-331-2104). If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

KP-MAS Formulary can be found at: [Pharmacy | Community Provider Portal | Kaiser Permanente](#)

**1 – Patient Information**

Patient Name: \_\_\_\_\_ Kaiser Medical ID#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**2 – Prescriber Information**

Prescriber Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ NPI: \_\_\_\_\_

Prescriber Address: \_\_\_\_\_

Prescriber Phone #: \_\_\_\_\_ Prescriber Fax #: \_\_\_\_\_

**3 – Pharmacy Information**

Pharmacy Name: \_\_\_\_\_ Pharmacy NPI: \_\_\_\_\_

Pharmacy Phone # \_\_\_\_\_ Pharmacy Fax #: \_\_\_\_\_

**4 – Drug Therapy Requested**

Drug 1: Name/Strength/Formulation: \_\_\_\_\_

Sig: \_\_\_\_\_

Drug 2: Name/Strength/Formulation: \_\_\_\_\_

Sig: \_\_\_\_\_

**5– Diagnosis/Clinical Criteria**

1. Is this request for initial or continuing therapy?

Initial therapy                       Continuing therapy, state start date: \_\_\_\_\_

2. Indicate the patient’s diagnosis for the requested medication: \_\_\_\_\_

**Clinical Criteria:**

1. Is the prescriber a Dermatologist?  
 No  Yes

**If treating atopic dermatitis:**

2. Does the patient have a diagnosis of mild to moderate atopic dermatitis?  
 No  Yes
3. Is the patient immunocompromised?  
 No  Yes
4. Has the patient had inadequate response, contraindication or intolerance to ALL of the following?  
  - At least one moderate- to very high-potency topical corticosteroid (2-weeks trial)
  - At least one topical calcineurin inhibitor (6-weeks trial)
  - Eucrisa (4-weeks trial) No  Yes

**If treating vitiligo:**

1. Does the patient have a diagnosis of vitiligo?  
 No  Yes
2. Has the patient had an inadequate response or contraindication to at least a 3-month trial of phototherapy unless involvement in sensitive areas (e.g. face, body folds, etc.)?  
 No  Yes
3. Has the patient had an inadequate response, contraindication or intolerance to ALL of the following?  
  - At least one moderate- to very high-potency corticosteroid (2-week trial)
  - At least one topical calcineurin inhibitor (2-month trial) No  Yes

**For continuation of therapy, please respond to additional questions below:**

1. Is there documentation of positive clinical response?  
 No  Yes
2. Has specialist follow-up occurred since last review?  
 No  Yes

**6 – Prescriber Sign-Off**

**Additional Information –**

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

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**I certify that the information provided is accurate. Supporting documentation is available for State audits.**

**Prescriber Signature:**

**Date:**

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