Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Opzelura (ruxolitinib) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 3 months; Continuation- 6 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. Prescriber is a Dermatologist, **AND**
   □ No □ Yes

If treating atopic dermatitis:

2. Patient has diagnosis of mild to moderate atopic dermatitis,
   □ No □ Yes

3. **AND** patient is non-immunocompromised,
   □ No □ Yes

4. **AND** patient has tried a 2-week trial of at least 1 moderate- to very high-potency topical corticosteroid unless clinically significant adverse effects, contraindication, or clinical reason to avoid treatment,
   □ No □ Yes

5. **AND** patient has tried a 6-week trial of at least 1 topical calcineurin inhibitor unless clinically significant adverse effects, contraindication, or clinical reason to avoid treatment,
   □ No □ Yes

6. **AND** patient has tried a 4-week trial of Eucrisa unless clinically significant adverse effects, contraindication, or clinical reason to avoid treatment
   □ No □ Yes

If treating vitiligo:

7. Patient has diagnosis of vitiligo,
   □ No □ Yes

8. **AND** patient has 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

9. **AND** patient has tried a 2-week trial of at least 1 moderate- to very high-potency corticosteroid unless clinically significant adverse effects, contraindication, or clinical reason to avoid treatment,
   □ No □ Yes

10. **AND** patient has tried a 2-month trial of at least 1 topical calcineurin inhibitor unless clinically significant adverse effects, contraindication, or clinical reason to avoid treatment
    □ No □ Yes

For continuation of therapy, please respond to <u>additional questions</u> below:

1. Documentation of positive clinical response,
   □ No □ Yes

2. **AND** 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:**

_____

_____

_____

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

Prescriber Signature:	**Date:**