



Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Litfulo (ritlecitinib)**. Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: [1-866-331-2104](tel:1-866-331-2104)]. If you have any questions or concerns, please call [1-866-331-2103](tel:1-866-331-2103). **Requests will not be considered unless this form is complete.**

The 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 #: _____

Do you have an approved provider referral number from Kaiser Permanente?

Yes – please provide your provider referral number here: _____

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
2. Is the patient 12 years of age or older?
 No Yes

If treating diagnosis of alopecia areata (with <50% scalp involvement, mild facial involvement, not rapidly progressive, not alopecia totalis/universalis):

3. Has the patient tried a 2-month trial of all of the following unless clinically significant adverse effects, contraindication, or clinical reason to avoid treatment?
 - Topical corticosteroid,
 - AND topical calcineurin inhibitor,
 - AND topical minoxidil,
 - AND intralesional Kenalog,
 - AND topical JAK inhibitor No Yes
4. Has the patient tried a 3-month trial of at least one of the systemic immunosuppressants such as methotrexate or cyclosporine unless clinically significant adverse effects, contraindication, or clinical reason to avoid treatment?
 No Yes

If treating diagnosis of alopecia areata (with >50% scalp involvement, disfiguring facial involvement, rapidly progressive, alopecia totalis/universalis):

5. Has the patient tried a 3-month trial of at least one of the systemic immunosuppressants such as methotrexate or cyclosporine unless clinically significant adverse effects, contraindication, or clinical reason to avoid treatment?
 No Yes

For Continuation of Therapy, please respond to additional questions below:

1. Has the patient experienced positive clinical response?
 No Yes
2. Has specialist follow-up occurred in the past 12 months 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:

Please Note: This document contains confidential information, including protected health information, intended for a specific individual and purpose. The information is private and legally protected by law, including HIPAA. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action in reliance on the contents of this telecopied information is strictly prohibited. Please notify sender if document was not intended for receipt by your facility