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

<u>If treating atopic dermatitis:</u>

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

<u>If treating vitiligo:</u>

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 <u>additional questions</u> 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:**

_____
_____
_____

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	