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

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]. If you have any questions or concerns, please call 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

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

3. Has the patient tried a 2-month trial of <u>all of the following</u> 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

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

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