US Family Health Plan Prior Authorization Request Form for ruxolitinib cream (**Opzelura**)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OF

The patient may attach the completed form to the prescription and mail it to:

Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? Call 1-877-880-7007

Initial approvals expire after twelve months, renewal approvals are indefinite. For renewal of therapy, an initial USFHP prior authorization approval is required.

1. Provider acknowledges that use of Opzelura for nonsegmental vitiligo is excluded by federal regulation (32CFR199.4 (e)(8)). 2. What is the indication for Opzelura? Atopic Dermatitis Vitiligo	Step	Please complete patient and physician information (please print):				
Address: Sponsor ID #	1	Patient Name:	Physician Name:			
Date of Birth: Secure Fax #:	•	Address:	- · ·			
Date of Birth: Secure Fax #:						
Please complete the clinical assessment: 1. Provider acknowledges that use of Opzelura for nonsegmental vitiligo is excluded by federal regulation (32CFR199.4 (e)(8)). 2. What is the indication for Opzelura? Atopic Dermatitis Vitiligo Proceed to question 3 STOP		Sponsor ID #	Phone #:			
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nonsegmental vitiligo is excluded by federal regulation (32CFR199.4 (e)(8)). 2. What is the indication for Opzelura? Atopic Dermatitis Vitiligo	Step 2	Please complete the clinical assessment:				
3. Has the patient received this medication under the USFHP benefit in the last 6 months? Please choose "No" if the patient did not previously have a USFHP approved PA for Opzelura. 4. Has the patient had a positive response to therapy, for example, an Investigator's Static Global Assessment (ISGA) score of clear (0) or almost clear? 5. Has the patient's disease severity improved and stabilized to warrant continued therapy? 6. What is the indication or diagnosis? Proceed to question 3 STOP Yes Proceed to question 4 Proceed to question 5 Proceed to question 5 STOP Coverage not approve Sign and date below STOP Coverage not approve STOP Coverage not approve All to moderate or uncontrolled atopic dermatitis - Proceed to question 7		nonsegmental vitiligo is excluded by federal				
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Sign and date below STOP Coverage not approve 6. What is the indication or diagnosis? □ Mild to moderate or uncontrolled atopic dermatitis - Proceed to question 7			☐ Yes	□ No		
6. What is the indication or diagnosis? □ Mild to moderate or uncontrolled atopic dermatitis - Proceed to question 7			Sign and date below	STOP		
Proceed to question 7				Coverage not approved		
☐ Other - STOP Coverage not approved		6. What is the indication or diagnosis?		☐ Mild to moderate or uncontrolled atopic dermatitis - Proceed to question 7		
			☐ Other - STOP Coverage r	☐ Other - STOP Coverage not approved		
7. Is the patient 12 years of age or older?		7. Is the patient 12 years of age or older?	☐ Yes	□ No		
Proceed to question 8 STOP			Proceed to question 8	STOP		
Coverage not approve				Coverage not approved		
8. Is the requested medication being prescribed by a		8. Is the requested medication being prescribed by a dermatologist, allergist, or immunologist?	a	□ No		
dermatologist, allergist, or immunologist? Proceed to question 9 STOP						
				Coverage not approved		

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9. How old is the patient?	9. How old is the patient?			
	☐ 12 to 17 years of age — Proceed to question 11☐ Other — STOP Coverage not approved			
 Does the patient have a contraindication to, intolerability to, or have they failed treatment with 	☐ Yes	□ No		
one medication in the following category: topical corticosteroids - high potency/class 1 topical	Proceed to question 12	STOP		
corticosteroids - high potency/class i topical corticosteroid (for example, clobetasol propionate 0.05% ointment/cream, fluocinonide 0.05% ointment/cream)?		Coverage not approved		
11. Does the patient have a contraindication to,	□ Yes	□ No		
intolerability to, or have they failed treatment with one medication in the following category: topical	Proceed to question 12	STOP		
corticosteroids, can be any topical corticosteroid, including low potency steroids?		Coverage not approved		
12. Does the patient have a contraindication to, intolerability to, or have they failed treatment with	☐ Yes	□ No		
one medication in the following category: topical	Proceed to question 13	STOP		
calcineurin inhibitor (for example, pimecrolimus, tacrolimus)?		Coverage not approved		
13. Is the patient using other immunobiologics	☐ Yes	□ No		
concomitantly (for example, Humira, Stelara etc), other JAK inhibitors (for example, Xeljanz, Olumiant,	STOP	Sign and date below		
Rinvoq), or potent immunosuppressants such as azathioprine or cyclosporine?	Coverage not approved			
I certify the above is true to the best of my knowl	I certify the above is true to the best of my knowledge. Please sign and date:			
3				
Prescriber Signature	Date			
		[16 May 2023]		