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

OR

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.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: ____________________ Physician Name: ____________________
Address: ____________________ Address: ____________________
____________________ ____________________
Sponsor ID #: ____________________ Phone #: ____________________
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

Question		
1. Provider acknowledges that use of Opzelura for nonsegmental vitiligo is excluded by federal regulation (32CFR199.4 (e)(8)).	☐ Acknowledge Proceed to question **2**	
2. What is the indication for Opzelura?	☐ Atopic Dermatitis - Proceed to question **3** ☐ Vitiligo - **STOP Coverage not approved** ☐ Other - **STOP Coverage not approved**	
3. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for Opzelura.*	☐ Yes Proceed to question **4**	☐ No Proceed to question **6**
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?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Has the patient's disease severity improved and stabilized to warrant continued therapy?	☐ Yes **Sign and date below**	☐ No **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 not approved**	
7. Is the patient 12 years of age or older?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**

8. Is the requested medication being prescribed by a dermatologist, allergist, or immunologist?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. How old is the patient?	☐ 18 years of age or older - Proceed to question **10** ☐ 12 to 17 years of age – Proceed to question **11** ☐ Other – **STOP Coverage not approved**	
10. Does the patient have a contraindication to, intolerability to, or have they failed treatment with one medication in the following category: topical corticosteroids - high potency/class 1 topical corticosteroid (for example, clobetasol propionate 0.05% ointment/cream, fluocinonide 0.05% ointment/cream)?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
11. Does the patient have a contraindication to, intolerability to, or have they failed treatment with one medication in the following category: topical corticosteroids, can be any topical corticosteroid, including low potency steroids?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. Does the patient have a contraindication to, intolerability to, or have they failed treatment with one medication in the following category: topical calcineurin inhibitor (for example, pimecrolimus, tacrolimus)?	☐ Yes Proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Is the patient using other immunobiologics concomitantly (for example, Humira, Stelara etc), other JAK inhibitors (for example, Xeljanz, Olumiant, Rinvoq), or potent immunosuppressants such as azathioprine or cyclosporine?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature ____________________ Date __________

[08 April 2024]