

**USFHP 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

<https://www.usfamilyhealth.org/for-providers/pharmacy-information/>

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

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

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

Step 2 Please complete the clinical assessment:

2	1. Provider acknowledges that use of Opzelura for nonsegmental vitiligo is excluded by federal regulation (32CFR199.4 (e)(8)).	<input type="checkbox"/> Acknowledge Proceed to question 2	
	2. What is the indication for Opzelura?	<input type="checkbox"/> Atopic Dermatitis - Proceed to question 3 <input type="checkbox"/> Vitiligo - STOP Coverage not approved <input type="checkbox"/> 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.	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No STOP Coverage not approved
	5. Has the patient's disease severity improved and stabilized to warrant continued therapy?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved
	6. What is the indication or diagnosis?	<input type="checkbox"/> Mild to moderate or uncontrolled atopic dermatitis - Proceed to question 7 <input type="checkbox"/> Other - STOP Coverage not approved	

<p>7. Is the patient 2 years of age or older?</p>	<p><input type="checkbox"/> Yes Proceed to question 8</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>8. Is the requested medication being prescribed by a dermatologist, allergist, or immunologist?</p>	<p><input type="checkbox"/> Yes Proceed to question 9</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>9. How old is the patient?</p>	<p><input type="checkbox"/> 18 years of age or older - Proceed to question 10 <input type="checkbox"/> 2 to 17 years of age – Proceed to question 11 <input type="checkbox"/> Other – STOP Coverage not approved</p>	
<p>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)?</p>	<p><input type="checkbox"/> Yes Proceed to question 12</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>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?</p>	<p><input type="checkbox"/> Yes Proceed to question 12</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>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)?</p>	<p><input type="checkbox"/> Yes Proceed to question 13</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>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?</p>	<p><input type="checkbox"/> Yes STOP Coverage not approved</p>	<p><input type="checkbox"/> No Sign and date below</p>

**Step
3**

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

Prescriber Signature

Date