HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM

OPZELURA™ FOR TREATMENT OF NONSEGMENTAL VITILIGO

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Opzelura™ (ruxolitinib)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is the request by, or in consultation with, a dermatologist?	☐	☐	**Please provide documentation**
2. Have other causes of depigmentation been ruled out (e.g., nevus depigmentosus, pityriasis alba, idiopathic guttate hypomelanosis, tinea (pityriasis) versicolor, halo nevus, piebaldism, progressive macular hypomelanosis, lichen sclerosus, chemical leukoderma, drug-induced leukoderma, hypopigmented mycosis fungoides)?	☐	☐	**Please provide documentation**
3. Does the affected area exceed 10% body surface area?	☐	☐	**Please provide documentation**
4. Does the member have history of failure, contraindication, or intolerance to ALL of the following? • Two medium to high potency corticosteroids (e.g., triamcinolone acetonide 0.1%, mometasone furoate 0.1%, betamethasone dipropionate 0.05%, desoximetasone 0.05%) • Topical calcineurin inhibitor, such as pimecrolimus or tacrolimus • Phototherapy	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does clinical documentation show achievement and maintenance of positive clinical response?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.
Additional information:
Physician Signature:

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Policy: PHARM-CHIP-156
Origination Date: 07/01/2024
Reviewed/Revised Date:
Next Review Date:
Current Effective Date: 07/01/2024