REALRx

PRIOR AUTHORIZATION REQUEST FORM
OPZELURA

For authorization, please answer each question and fax this form PLUS chart notes back to Real Rx 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 this request for an **expedited** review? By checking the **"Yes"** box to request an expedited review (24 hours), you are certifying that applying the standard review time frame (72 hours) may place the member's life, health, or ability to regain maximum function in serious jeopardy.	☐	☐	
2. Is the request made by a provider specializing in dermatology, allergy, or immunology?	☐	☐	
3. Does documentation show a confirmed diagnosis of mild to moderate atopic dermatitis in a non-immune compromised individual who is not adequately controlled with topical prescription therapies or when these therapies are not advisable?	☐	☐	**Please provide documentation**
4. Is the affected area less than 20% of body surface area?	☐	☐	**Please provide documentation**
5. Does the quantity requested exceed one tube per 30 days?	☐	☐	**Please provide documentation**
6. Has the member had an adequate trial with the following: • a topical calcineurin inhibitor, such as pimecrolimus or tacrolimus, • two medium to high potency corticosteroids (e.g., triamcinolone acetonide 0.1%, mometasone furoate 0.1%, betamethasone dipropionate 0.05%, desoximetasone 0.05%), and • phototherapy?	☐	☐	**Please provide documentation**

REAUTHORIZATION			
1. Is the request for reauthorization of atopic dermatitis therapy?	☐	☐	
2. Is there evidence 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-141
Origination Date: 05/18/2022
Reviewed/Revised Date: 01/18/2023
Next Review Date: 01/18/2024
Current Effective Date: 02/01/2023