

HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM OPZELURA® FOR VITILIGO

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

- For **Medical Pharmacy** please fax requests to: 801-213-1547
- For **Retail Pharmacy** please fax requests to: 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 Pharmacy Customer Service for assistance at 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:	HCPCS Code:	

Member must try formulary preferred drugs before a request for a non-formulary 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?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does the member have a confirmed diagnosis of nonsegmental vitiligo?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Is the requested area for treatment ≤10% of the body surface area (BSA)?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Are any of the following causes of vitiligo present: 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)?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. Has the member had an adequate trial with the following, where appropriate: <ul style="list-style-type: none"> • A medium to high potency corticosteroid (e.g., mometasone furoate 0.1%, clobetasol propionate 0.25%, betamethasone dipropionate 0.05%, desoximetasone 0.05%) • A topical calcineurin inhibitor, such as pimecrolimus or tacrolimus • Phototherapy 	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation

REAUTHORIZATION

1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
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2. Does updated documentation show that the member has a continued medical need and that the therapy is tolerable and effective?	<input type="checkbox"/>	<input type="checkbox"/>	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:			

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

Policy: PHARM-CHIP-170
 Origination Date: 11/04/2025
 Reviewed/Revised Date: 11/12/2025
 Next Review Date: 11/12/2026
 Current Effective Date: 12/01/2025

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