REALRx

Healthy U
Health Choice Utah

PRIOR AUTHORIZATION REQUEST FORM
OPZELURA® FOR VITILIGO

For authorization, please answer each question and fax this form PLUS chart notes back to the RealRx Medicaid 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 Pharmacy Customer Service for assistance.

- Healthy U Medicaid: 855-856-5694
- Health Choice Utah: 855-864-1404

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?	☐	☐	
2. Does the member have a confirmed diagnosis of nonsegmental vitiligo?	☐	☐	**Please provide documentation**
3. Is the requested area for treatment ≤10% of the body surface area (BSA)?	☐	☐	**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)?	☐	☐	**Please provide documentation**
5. Has the member had an adequate trial with the following, where appropriate: • 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	☐	☐	**Please provide documentation**

REAUTHORIZATION			
1. Is the requesting for reauthorization of therapy?	☐	☐	
2. Does updated documentation show that the member has a continued medical need and that the therapy is tolerable and effective?	☐	☐	**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:			

PRESCRIBER CERTIFICATION	
I hereby certify this treatment is indicated, necessary and meets the guidelines for use.	
Physician's Signature:	**Date:**

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Policy: PHARM-MM- 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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