PRIOR AUTHORIZATION REQUEST

Opzelura

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

1	Is the request an INITIAL or CONTINUATION of therapy? [] Initial (If checked, go to 5) [] Continuation (If checked, go to 2)		
2	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.]	Yes	No

If you have any questions, call: 1-888-258-8250

PRIOR AUTHORIZATION REQUEST

	[If no, skip to question 5.]		
3	What is the indication or diagnosis? [] Atopic dermatitis (If checked, go to 4) [] Vitiligo (If checked, no further questions) [] Other (If checked, no further questions)		
4	Has the patient been taking the requested medication for at least 3 months and has experienced a clinically significant benefit from the medication, as documented by the prescriber? [Note: Examples of a response to the requested medication are marked improvements in erythema, induration/papulation/edema, excoriations, and lichenification; reduced pruritus; decreased requirement for other topical or systemic therapies; reduced body surface area affected with atopic dermatitis; or other responses observed.] [No further questions.]	Yes	No
5	What is the indication or diagnosis? [] Atopic dermatitis (If checked, go to 6) [] Vitiligo (If checked, no further questions) [] Other (If checked, no further questions)		
6	Is the patient greater than or equal to 12 years of age? [If no, no further questions.]	Yes	No
7	Does the patient have a documented diagnosis of mild to moderate atopic dermatitis? [If no, no further questions.]	Yes	No
8	Is the requested medication being prescribed by or in consultation with an allergist, immunologist, or dermatologist? [If no, no further questions.]	Yes	No
9	Does the patient have atopic dermatitis involvement estimated to be 3% to 20% of the body surface area (BSA) according to the prescriber? [If no, no further questions.]	Yes	No
10	Has the patient tried at least TWO medium-, medium-high, high-, and/or super-high-potency prescription topical corticosteroids? [If no, no further questions.]	Yes	No
11	Was inadequate efficacy demonstrated with the topical corticosteroid therapy,	Yes	No

PRIOR AUTHORIZATION REQUEST

	according to the prescriber? [If no, no further questions.]		
12	Has the patient tried a topical calcineurin inhibitor (pimecrolimus or tacrolimus) for at least 28 consecutive days? [If no, no further questions.]	Yes	No
13	Was inadequate efficacy demonstrated with the topical calcineurin inhibitor (pimecrolimus or tacrolimus), according to the prescriber? [If no, no further questions.]	Yes	No
14	Has the patient tried Zoryve for at least 4 weeks? [If no, no further questions.]	Yes	No
15	Was inadequate efficacy demonstrated with Zoryve, according to the prescriber? [If no, no further questions.]	Yes	No
16	Will the requested medication be used in combination with therapeutic biologics, other JAK inhibitors such as Tofacitinib (Xeljanz), Baricitinib (Olumiant), Upadacitinib (Rinvoq), and Otelixinib (Argotra) or potent immunosuppressants such as azathioprine or cyclosporine?	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

If you have any questions, call: 1-888-258-8250

PRIOR AUTHORIZATION REQUEST