BlueCross BlueShield
Federal Employee Program

OPZELURA
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Opzelura (ruxolitinib)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

How many tubes will the patient need over the course of a year? _____ tube(s) per year

1. Is the patient immunocompromised? ❑Yes ❑No

2. Does the patient have any active bacterial, invasive fungal, viral, or other opportunistic infection present? ❑Yes ❑No

3. Has the prescriber assessed the patient's risk factors for malignancy and major adverse cardiovascular events (MACE) (such as advanced age, smoking history, etc) and determined that Opzelura therapy is appropriate? ❑Yes ❑No

4. Will Opzelura be used in combination with potent immunosuppressants such as azathioprine or cyclosporine? ❑Yes ❑No

5. What is the patient's diagnosis?
   ❑Nonsegmental vitiligo
   a. Has the patient been on Opzelura continuously for the last **6 months**, excluding samples? ***Please select answer below:***

   ❑**NO** – this is **INITIATION** of therapy, please answer the following questions:
   i. Does the prescriber agree to evaluate the patient for latent and active TB infections prior to and during treatment with Opzelura therapy, as appropriate? ❑Yes ❑No
   ii. Have other causes of depigmentation been ruled out? ❑Yes ❑No
   iii. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a topical calcineurin inhibitor such as Elidel (pimecrolimus) or Protopic (tacrolimus)? ❑Yes ❑No
   iv. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a topical corticosteroid? ❑Yes ❑No

   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:
   i. Has the patient's condition improved or stabilized with therapy? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ **DOB:** _____ **Patient ID: R** _____

❑Atopic dermatitis (eczema)

a. Does the prescriber agree that treatment will be stopped when signs and symptoms resolve **OR** that the patient will be treated for no longer than eight weeks at a time? ❑Yes ❑No

b. Will Opzelura be used in combination with another Topical Prior Authorization (PA) medication for atopic dermatitis (eczema)? ❑Yes***** ❑No
If YES, please specify the medication: _____

c. Has the patient been on Opzelura continuously for the last **6 months**, excluding samples? ***Please select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

i. Does the prescriber agree to evaluate the patient for latent and active TB infections prior to and during treatment with Opzelura therapy, as appropriate? ❑Yes ❑No

ii. Does the patient have a diagnosis of mild to moderate atopic dermatitis (eczema)? ❑Yes ❑No

iii. Does the prescriber agree that treatment will be stopped when signs and symptoms resolve **OR** that the patient will be treated for no longer than eight weeks at a time? ❑Yes ❑No

iv. Does the patient have a documented baseline evaluation of their condition using **ONE** of the following scoring tools: Investigator's Static Global Assessment (ISGA) score, Eczema Area and Severity Index (EASI), Patient Oriented Eczema Measure (POEM), or Scoring Atopic Dermatitis (SCORAD) index? ❑Yes ❑No

v. **Age 12-17**: Please answer the following questions:
1) Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a topical corticosteroid? ❑Yes ❑No
2) Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a topical calcineurin inhibitor such as Elidel (pimecrolimus) or Protopic (tacrolimus)? ❑Yes ❑No

vi. **Age 18 or Older**: Please answer the following questions:
1) Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a high potency topical corticosteroid such as Amcinonide, Fluocinonide, or Halcinonide? ❑Yes ❑No
2) Does the patient have lesions on their face, neck, or skin folds? ❑Yes* ❑No
If YES, does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a low to medium potency topical corticosteroid? ❑Yes ❑No
3) Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a topical calcineurin inhibitor such as Elidel (pimecrolimus) or Protopic (tacrolimus)? ❑Yes ❑No

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

i. Which scoring tool was used to obtain the patient's baseline status? ***Please select answer below:***

❑Eczema Area and Severity Index (EASI)
1) Does the patient have a documented improvement from baseline by at least 75%? ❑Yes ❑No

❑Investigator's Static Global Assessment (ISGA) score
1) Does the patient have a documented improvement from baseline by at least 2 points? ❑Yes ❑No

❑Patient-Oriented Eczema Measure (POEM)
1) Does the patient have a documented improvement from baseline by at least 3 points? ❑Yes ❑No

❑**Sc**oring Atopic Dermatitis (SCORAD) index
1) Does the patient have a documented decrease from baseline by at least 50%? ❑Yes ❑No

❑None of the above

Scoring Tools:

Eczema Area and Severity Index (EASI): https://dermnetnz.org/topics/easi-score/

Investigator's Static Global Assessment (ISGA) score: https://www.eczemacouncil.org/assets/docs/Validated-Investigator-Global-Assessment-Scale_vIGA-AD_2017.pdf

Patient-Oriented Eczema Measure (POEM): https://jamanetwork.com/data/Journals/DERM/11776/dea40003f1.png

Scoring Atopic Dermatitis (SCORAD) index: https://dermnetnz.org/topics/scorad/