

Reference number(s)
7364-D

This document applies to the following:

Formulary	Applies
Standard Control (SF)	<input type="checkbox"/>
Standard Control Choice (SCCF)	<input type="checkbox"/>
Preferred Drug Plan Design (PDPD)	<input type="checkbox"/>
Advanced Control Specialty (ACSF)	<input checked="" type="checkbox"/>
Advanced Control Specialty Choice (ACSCF)	<input checked="" type="checkbox"/>
Managed Medicaid Template (MMT)	<input type="checkbox"/>
Marketplace (MF)	<input type="checkbox"/>
Aetna Small Group Affordable Care Act (SG ACA)	<input type="checkbox"/>
Aetna Health Exchange (AHE)	<input type="checkbox"/>
Value (VF)	<input checked="" type="checkbox"/>

Formulary	Applies
New to Market (NTM)	<input type="checkbox"/>
Standard Formulary Chart (SFC)	<input type="checkbox"/>
Basic Control Chart Preferred Drug Plan Design (BCC PDPD)	<input type="checkbox"/>
Advanced Control Specialty Formulary Chart (ACSFC)	<input checked="" type="checkbox"/>
Value Formulary Chart (VFC)	<input checked="" type="checkbox"/>
Medical Benefit	<input type="checkbox"/>
Medical Benefit: Advanced Biosimilars First	<input type="checkbox"/>
Combined Benefit Management (CBM)	<input type="checkbox"/>
Combined Benefit Management Pharmacy (CBMP)	<input checked="" type="checkbox"/>
Medical Benefit Managed Medicaid (MMMB)	<input type="checkbox"/>

Exceptions Criteria

Alopecia Areata

This document informs prescribers of preferred products and provides an exception process for targeted products through prior authorization.

These criteria were developed to align with the following: Advanced Control Specialty Formulary (ACSF), Advanced Control Specialty Choice Formulary (ACSCF), Value Formulary (VF), Advanced Control Specialty Formulary Chart (ACSFC), Value Formulary Chart (VFC), and Combined Benefit Management Pharmacy (CBMP).

Plan Design Summary

This program applies to the alopecia areata products specified in this document. Coverage for the targeted product is provided based on clinical circumstances that would exclude the use of the preferred product and may be based on previous use of a product. The coverage review process will ascertain situations where a clinical exception can be made. This program applies to all members requesting treatment with the targeted product.

Each referral is reviewed based on all utilization management (UM) programs implemented for the client.

Table. Alopecia Areata

Medications considered formulary or preferred on your plan may still require a clinical prior authorization review.

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	Product(s)
Preferred	<ul style="list-style-type: none"> • Litfulo (ritlecitinib) • Olumiant (baricitinib)
Target	<ul style="list-style-type: none"> • Leqselvi (deuruxolitinib)

Exception Criteria

This program applies to members requesting treatment for an indication that is FDA-approved for the preferred product.

Member has a documented inadequate response or intolerable adverse event with both of the preferred products (Litfulo and Olumiant).

References

1. Leqselvi [package insert]. Whippany, NJ: Sun Pharmaceuticals Industries, Inc.; July 2024.
2. Litfulo [package insert]. New York, NY: Pfizer Inc.; June 2023.
3. Olumiant [package insert]. Indianapolis, IN: Lilly USA, LLC; June 2022.