Mountain-Pacific Quality Health
Partnering within our communities to provide solutions for better health
P.O. Box 5119, Helena, MT 59604
Phone 406.443.6002 . Toll-Free 1.800.395.7961
Fax 406.513.1928 . Toll-Free 1.800.294.1350

Montana Healthcare Progams Prior Authorization Request Form for Use of Opzelura (ruxolitinib)

Member Name:	DOB:	Date:
Member ID:	Prescriber Phone:	
Prescriber Name/Specialty if applicable:	Prescriber Fax:	

Please complete below information for applicable situation, Initiation or Continuation of therapy:

☐ INITIATION OF THERAPY

1. Member must be ≥ 12 years of age: ☐ Yes ☐ No
2. Member has a diagnosis of mild to moderate atopic dermatitis: ☐ Yes ☐ No
3. Member has had a documented baseline assessment to allow for documentation of positive clinical response: ☐ Yes ☐ No
4. Member has had an inadequate treatment response, intolerance, or contraindication to a **preferred low-mild** potency topical corticosteroid: ☐ Yes ☐ No

   Drug name and date used: _____
5. **Members 18 years of age or older**: Member has had an inadequate treatment response, intolerance or contraindication to a **preferred high** potency topical corticosteroid.

   Drug name and date used: _____
6. Member must **also** have had an inadequate treatment response, intolerance, or contraindication to one of the following (*subject to preferred drug list requirements*):
   - ☐ Elidel (pimecrolimus) Date: _____
   - ☐ Protopic (tacrolimus) Date: _____
7. Member has had an inadequate treatment response, intolerance, or contraindication to Eucrisa (crisaborole): ☐ Yes ☐ No Date used: _____

   NOTE: Inadequate treatment response to topical therapy is defined as failure to achieve and maintain remission or a low disease activity state despite treatment with a daily regimen, applied for ≥ 28 days or for the maximum duration recommended by the product prescribing information (e.g., 14 days for high or very-high potency topical corticosteroids).
8. Provider attests that member **WILL NOT** use Opzelura in combination with therapeutic biologics, other Janus kinase inhibitors, or potent immunosuppressants such as azathioprine or cyclosporine: ☐ Yes ☐ No

LIMITATIONS:
A maximum of 4-60gm tubes per month will be authorized.

Initial authorization will be issued for 8 weeks.

☐ CONTINUATION OF THERAPY

Does the member have documentation of positive clinical response to Opzelura therapy (e.g., reduction in body surface area involvement, reduction in pruritus severity or decrease in severity index using a scoring tool)?
☐ Yes ☐ No

Reauthorization will be issued for 6 months.

Please complete form, including required attachments and fax to Drug Prior Authorization Unit at 1-800-294-1350.

03/2022