

OPZELURA

PRIOR AUTHORIZATION REQUEST

PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is REQUIRED. Incomplete forms will be returned for additional information. For formulary information please visit www.myprime.com. Start saving time today by filling out this form electronically. Visit covermymeds.com to begin using this free service.

What is the priority level of this request?

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient’s life, health or ability to regain maximum function

Today’s Date: _____

PATIENT AND INSURANCE INFORMATION

Date of Service (if differs from Today’s Date): _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient’s Diagnosis: <input type="checkbox"/> Mild to moderate atopic dermatitis (AD) <input type="checkbox"/> Nonsegmental vitiligo (NSV) <input type="checkbox"/> Other (ICD code plus description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
For all requests: 1. Is the patient currently treated with the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, was the treatment started on samples? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is the patient at risk if therapy is changed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify risk: _____ _____	
2. Does the patient have any FDA labeled contraindications to the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify contraindication(s): _____ _____	
3. Will the patient be using the requested agent in combination with another immunomodulatory agent (e.g., TNF inhibitors, JAK inhibitors, IL-4 inhibitors) [Abrilada, Actemra, Adalimumab, Adbry, Amjevita, Arcalyst, Avsola, Avtozma, Benlysta, Bimzelx, Cibirgo, Cimzia, Cinqair, Cosentyx, Cyltezo, Dupixent, Ebglyss, Enbrel, Entyvio, Fasenra, Hadlima, Hulio, Humira, Hyrimoz, Idacio, Ilaris, Ilumya, Imuldosa, Inflectra, Infliximab, Kevzara, Kineret, Leqselvi, Litfulo, Nemludio, Nucala, Olumiant, Omlyclo, Omvoh, Opzelura, Orenicia, Otezla, Otulfi, Pyzchiva, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Rituxan Hycela, Ruxience, Saphnelo, Selarsdi, Siliq, Simlandi, Simponi, Simponi ARIA, Skyrizi, Sotyktu, Spevigo subcutaneous injection, Starjemza, Stelara, Steqeyma, Taltz, Tezspire, Tofidence, Tremfya, Truxima, Tyenne, Tysabri, Ustekinumab, Velsipity, Wezlana, Xeljanz, Xeljanz XR, Xolair, Yesintek, Yuflyma, Yusimry, Zeposia, Zymfentra]? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, does the prescribing information for the requested agent limit the use with another immunomodulatory agent? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, is there support for the use of combination therapy? Please note, a submitted copy of clinical trials, phase III studies, or guidelines is required. <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please submit supporting copy of clinical trials, phase III studies, and/or guidelines.	
Please continue to the next page.	

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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4. Is the patient's age within FDA labeling for the requested indication for the requested agent? Yes No
 If no, is there support for using the requested agent for the patient's age for the requested indication? Yes No
 If yes, please provide supporting information: _____

5. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., dermatologist), or has the prescriber consulted with a specialist in the area of the patient's diagnosis? Yes No

6. Please list all reasons for selecting the requested agent, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). **Please note, documentation may be required:** _____

For mild to moderate atopic dermatitis (AD) requests:

7. Is the patient immunocompromised? Yes No

8. Has the patient tried and had an inadequate response to ONE at least low-potency topical corticosteroid used in the treatment of AD after at least a 4-week duration of therapy? Yes No
 If yes, please specify tried agent: _____

If no, does the patient have an intolerance or hypersensitivity to ONE at least low-potency topical corticosteroid used in the treatment of AD? Yes No
 If yes, please explain intolerance/hypersensitivity: _____

If no, does the patient have an FDA labeled contraindication to ALL topical corticosteroids used in the treatment of AD? Yes No
 If yes, please specify FDA labeled contraindication: _____

9. Has the patient tried and had an inadequate response to ONE topical calcineurin inhibitor used in the treatment of AD after at least a 6-week duration of therapy? Yes No
 If yes, please specify tried agent: _____

If no, does the patient have an intolerance or hypersensitivity to ONE topical calcineurin inhibitor used in the treatment of AD? Yes No
 If yes, please explain intolerance/hypersensitivity: _____

If no, does the patient have an FDA labeled contraindication to ALL topical calcineurin inhibitors used in the treatment of AD? Yes No
 If yes, please specify FDA labeled contraindication: _____

10. Is the patient currently treated with topical emollients and practicing good skin care? Yes No
 If yes, will the patient continue the use of topical emollients and good skin care practices in combination with the requested agent? Yes No

For nonsegmental vitiligo (NSV) requests:

11. Is the patient's affected body surface area (BSA) less than or equal to 10%? Yes No

12. Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer? Yes No

If yes, is the use of the requested agent consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration? Yes No

If no, is there documentation that the patient has been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat an associated condition related to stage four advanced metastatic cancer? Please note: chart notes are required. Yes No
 If yes, please submit chart notes.

If yes, is the use of the requested agent consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration? Yes No

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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13. Has the patient tried and had an inadequate response to ONE at least medium-potency topical corticosteroid used in the treatment of NSV after at least a 12-week duration of therapy? Yes No
 If yes, please specify tried agent: _____
 If no, has the patient tried and had an inadequate response to ONE topical calcineurin inhibitor used in the treatment of NSV after at least a 12-week duration of therapy? Yes No
 If yes, please specify tried agent: _____
 If no, does the patient have an intolerance or hypersensitivity to ONE at least medium-potency topical corticosteroid OR topical calcineurin inhibitor used in the treatment of NSV? Yes No
 If yes, please explain intolerance/hypersensitivity: _____

 If no, does the patient have FDA labeled contraindication to ALL medium-, high-, and super-potency topical corticosteroids AND ALL topical calcineurin inhibitors used in the treatment of NSV? Yes No
 If yes, please specify FDA labeled contraindication: _____

For renewal requests:
 14. Has the patient had clinical benefit with the requested agent? Yes No

Please fax or mail this form to:
 Prime Therapeutics LLC
 Clinical Review Department
 2900 Ames Crossing Road Suite 200
 Eagan, MN 55121
TOLL FREE
Phone: **Fax: 877.243.6930**
BCBSIL: 800.285.9426
BCBSMT: 888.723.7443
BCBSNM: 800.544.1378
BCBSOK: 800.991.5643
BCBSTX: 800.289.1525

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