



# Anzupgo Prior Authorization with Quantity Limit Program Summary

## POLICY REVIEW CYCLE

**Effective Date**  
03-01-2026

**Date of Origin**  
11-13-2025

## POLICY AGENT SUMMARY PRIOR AUTHORIZATION

Target Brand Agent(s)	Target Generic Agent(s)	Strength	Targeted MSC	Available MSC	Final Age Limit	Preferred Status
Anzupgo	delgocitinib cream	20 MG/GM	M ; N ; O ; Y	N		

## POLICY AGENT SUMMARY QUANTITY LIMIT

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	QL Amount	Dose Form	Day Supply	Duration	Addtl QL Info	Allowed Exceptions	Targeted NDCs When Exclusions Exist
Anzupgo	delgocitinib cream	20 MG/GM	60	Grams	30	DAYS			

## CLIENT SUMMARY – PRIOR AUTHORIZATION

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Anzupgo	delgocitinib cream	20 MG/GM	Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL HMO Performance Quarterly ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods

## CLIENT SUMMARY – QUANTITY LIMITS

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Anzupgo	delgocitinib cream	20 MG/GM	Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ;

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			Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL HMO Performance Quarterly ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods

**PRIOR AUTHORIZATION CLINICAL CRITERIA FOR APPROVAL**

Module	Clinical Criteria for Approval
	<p><b>Initial Evaluation</b></p> <p><b>Target Agent(s)</b> will be approved when ALL of the following are met:</p> <ol style="list-style-type: none"> <li>1. ONE of the following: <ol style="list-style-type: none"> <li>A. The patient has a diagnosis of chronic hand eczema (CHE) AND ALL of the following: <ol style="list-style-type: none"> <li>1. The patient has hand eczema that has been present for greater than 3 months or has returned at least twice in a year after its initial presentation and subsequent clearance <b>AND</b></li> <li>2. The patient has moderate to severe disease severity <b>AND</b></li> <li>3. The patient has ONE of the following: <ol style="list-style-type: none"> <li>A. Tried and had an inadequate response to ONE at least medium-potency topical corticosteroid used in the treatment of CHE after at least a 4-week duration of therapy <b>OR</b></li> <li>B. An intolerance or hypersensitivity to ONE at least medium-potency topical corticosteroid used in the treatment of CHE <b>OR</b></li> <li>C. An FDA labeled contraindication to ALL topical corticosteroids used in the treatment of CHE <b>AND</b></li> </ol> </li> <li>4. BOTH of the following: <ol style="list-style-type: none"> <li>A. The patient is currently treated with topical emollients/moisturizers and is practicing good skin care <b>AND</b></li> <li>B. The patient will continue the use of topical emollients/moisturizers and good skin care practices in combination with the requested agent <b>OR</b></li> </ol> </li> </ol> </li> <li>B. The patient has another FDA labeled indication for the requested agent and route of administration <b>AND</b></li> </ol> </li> <li>2. If the patient has an FDA labeled indication, then ONE of the following: <ol style="list-style-type: none"> <li>A. The patient’s age is within FDA labeling for the requested agent <b>OR</b></li> <li>B. There is support for using the requested agent for the patient’s age for the requested indication <b>AND</b></li> </ol> </li> <li>3. The prescriber is a specialist in the area of the patient’s diagnosis (e.g., dermatologist, allergist, immunologist), or the prescriber has consulted with a specialist in the area of the patient’s diagnosis <b>AND</b></li> <li>4. ONE of the following (please refer to “Agents NOT to be used Concomitantly” table): <ol style="list-style-type: none"> <li>A. The patient will NOT be using the requested agent in combination with another immunomodulatory agent (e.g., TNF inhibitors, JAK inhibitors, IL-4 inhibitors) <b>OR</b></li> </ol> </li> </ol>

Module	Clinical Criteria for Approval
	<p data-bbox="375 180 1317 239">B. The patient will be using the requested agent in combination with another immunomodulatory agent AND BOTH of the following:</p> <ol data-bbox="469 239 1377 352" style="list-style-type: none"> <li data-bbox="469 239 1377 298">1. The prescribing information for the requested agent does NOT limit the use with another immunomodulatory agent <b>AND</b></li> <li data-bbox="469 298 1377 352">2. There is support for the use of combination therapy (submitted copy of clinical trials, phase III studies, or guidelines required) <b>AND</b></li> </ol> <p data-bbox="280 352 1354 384">5. The patient does NOT have any FDA labeled contraindications to the requested agent</p> <p data-bbox="232 422 496 453"><b>Length of Approval:</b></p> <p data-bbox="232 485 482 516">BCBSOK: 36 months</p> <p data-bbox="232 554 568 585">ALL other plans: 12 months</p> <p data-bbox="232 619 1081 651">NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria.</p> <p data-bbox="232 745 1281 777"><b>The requested agent will also be approved when ALL of the following are met:</b></p> <ol data-bbox="293 814 1414 1249" style="list-style-type: none"> <li data-bbox="293 814 751 846">1. The member resides in Ohio <b>AND</b></li> <li data-bbox="293 846 930 877">2. The plan is Fully Insured or HIM Shop (SG) <b>AND</b></li> <li data-bbox="293 877 1370 936">3. The patient does NOT have any FDA labeled contraindications to the requested agent <b>AND</b></li> <li data-bbox="293 936 599 968">4. ONE of the following: <ol data-bbox="375 968 1406 1249" style="list-style-type: none"> <li data-bbox="375 968 1406 1026">A. The patient has another FDA labeled indication for the requested agent and route of administration <b>OR</b></li> <li data-bbox="375 1026 1305 1085">B. The patient has another indication that is supported in compendia for the requested agent and route of administration <b>OR</b></li> <li data-bbox="375 1085 1414 1249">C. The prescriber has submitted TWO articles from major peer-reviewed professional medical journals [e.g., Journal of American Medical Association (JAMA), New England Journal of Medicine (NEJM), Lancet] supporting the proposed use(s) as generally safe and effective. Accepted study designs may include, but are not limited to, randomized, double blind, placebo controlled clinical trials. NOTE: Case studies are not acceptable [journal articles required]</li> </ol> </li> </ol> <p data-bbox="232 1287 1395 1346"><b>Non-oncology compendia allowed:</b> DrugDex level 1, 2A or 2B, AHFS-DI (narrative text must be supportive)</p> <p data-bbox="232 1383 1378 1472"><b>Oncology compendia allowed:</b> NCCN 1 or 2A, AHFS-DI (narrative text must be supportive), DrugDex level 1, 2A, or 2B, or Clinical Pharmacology (narrative text must be supportive), Lexi-Drugs evidence level A, peer-reviewed medical literature</p> <p data-bbox="232 1509 496 1541"><b>Length of Approval:</b></p> <p data-bbox="232 1575 482 1606">BCBSOK: 36 months</p> <p data-bbox="232 1644 568 1675">ALL other plans: 12 months</p> <p data-bbox="232 1709 1081 1740">NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria.</p> <p data-bbox="232 1835 496 1866"><b>Renewal Evaluation</b></p> <p data-bbox="232 1900 1081 1932"><b>Target Agent(s)</b> will be approved when ALL of the following are met:</p>

Module	Clinical Criteria for Approval
	<ol style="list-style-type: none"> <li>1. The patient has been previously approved for the requested agent through the plan's Prior Authorization process (Note: patients not previously approved for the requested agent will require initial evaluation review) <b>AND</b></li> <li>2. The patient has had clinical benefit with the requested agent <b>AND</b></li> <li>3. The patient will continue standard maintenance therapies (e.g., topical emollients/moisturizers, good skin care practices) in combination with the requested agent <b>AND</b></li> <li>4. The prescriber is a specialist in the area of the patient's diagnosis (e.g., dermatologist, allergist, immunologist), or the prescriber has consulted with a specialist in the area of the patient's diagnosis <b>AND</b></li> <li>5. ONE of the following (please refer to "Agents NOT to be used Concomitantly" table): <ol style="list-style-type: none"> <li>A. The patient will NOT be using the requested agent in combination with another immunomodulatory agent (e.g., TNF inhibitors, JAK inhibitors, IL-4 inhibitors) <b>OR</b></li> <li>B. The patient will be using the requested agent in combination with another immunomodulatory agent <b>AND BOTH</b> of the following: <ol style="list-style-type: none"> <li>1. The prescribing information for the requested agent does NOT limit the use with another immunomodulatory agent <b>AND</b></li> <li>2. There is support for the use of combination therapy (submitted copy of clinical trials, phase III studies, or guidelines required) <b>AND</b></li> </ol> </li> </ol> </li> <li>6. The patient does NOT have any FDA labeled contraindications to the requested agent</li> </ol> <p><b>Length of Approval:</b></p> <p>BCBSOK: 36 months</p> <p>ALL other plans: 12 months</p> <p>NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria.</p>

### QUANTITY LIMIT CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
	<p><b>Quantity Limit for the Target Agent(s)</b> will be approved when ONE of the following is met:</p> <ol style="list-style-type: none"> <li>1. The requested quantity (dose) does NOT exceed the program quantity limit <b>OR</b></li> <li>2. The requested quantity (dose) exceeds the program quantity limit <b>AND ONE</b> of the following: <ol style="list-style-type: none"> <li>A. <b>BOTH</b> of the following: <ol style="list-style-type: none"> <li>1. The requested agent does NOT have a maximum FDA labeled dose for the requested indication <b>AND</b></li> <li>2. There is support for therapy with a higher dose for the requested indication <b>OR</b></li> </ol> </li> <li>B. <b>BOTH</b> of the following: <ol style="list-style-type: none"> <li>1. The requested quantity (dose) does NOT exceed the maximum FDA labeled dose for the requested indication <b>AND</b></li> <li>2. There is support for why the requested quantity (dose) cannot be achieved with a lower quantity of a higher strength that does NOT exceed the program quantity limit <b>OR</b></li> </ol> </li> <li>C. <b>BOTH</b> of the following: <ol style="list-style-type: none"> <li>1. The requested quantity (dose) exceeds the maximum FDA labeled dose for the requested indication <b>AND</b></li> <li>2. There is support for therapy with a higher dose for the requested indication</li> </ol> </li> </ol> </li> </ol> <p><b>Length of Approval:</b> 12 months</p>

### CONTRAINDICATION AGENTS

**Contraindicated as Concomitant Therapy****Agents NOT to be used Concomitantly**

Abrilada (adalimumab-afzb)  
Actemra (tocilizumab)  
Adalimumab  
Adbry (tralokinumab-ldrm)  
Amjevita (adalimumab-atto)  
Arcalyst (rilonacept)  
Avsola (infliximab-axxq)  
Avtozma (tocilizumab-anoh)  
Benlysta (belimumab)  
Bimzelx (bimekizumab-bkzx)  
Cibinqo (abrocitinib)  
Cimzia (certolizumab)  
Cinqair (reslizumab)  
Cosentyx (secukinumab)  
Cyltezo (adalimumab-adbm)  
Dupixent (dupilumab)  
Ebglyss (lebrikizumab-lbkz)  
Enbrel (etanercept)  
Entyvio (vedolizumab)  
Fasenra (benralizumab)  
Hadlima (adalimumab-bwwd)  
Hulio (adalimumab-fkjp)  
Humira (adalimumab)  
Hyrimoz (adalimumab-adaz)  
Idacio (adalimumab-aacf)  
Ilaris (canakinumab)  
Ilumya (tildrakizumab-asmn)  
Imuldosa (ustekinumab-srlf)  
Inflectra (infliximab-dyyb)  
Infliximab  
Kevzara (sarilumab)  
Kineret (anakinra)  
Leqselvi (deuruxolitinib)  
Litfulo (ritlecitinib)  
Nemluvio (nemolizumab-ilto)  
Nucala (mepolizumab)  
Olumiant (baricitinib)  
Omlyclo (omalizumab-igec)  
Omvoh (mirikizumab-mrkz)  
Opzelura (ruxolitinib)  
Orencia (abatacept)  
Otezla (apremilast)  
Otezla XR (apremilast extended-release)  
Otulfi (ustekinumab-aaaz)  
Pyzchiva (ustekinumab-ttwe)  
Remicade (infliximab)  
Renflexis (infliximab-abda)  
Rhapsido (remibrutinib)  
Riabni (rituximab-arrx)  
Rinvoq (upadacitinib)  
Rituxan (rituximab)  
Rituxan Hycela (rituximab/hyaluronidase human)  
Ruxience (rituximab-pvvr)  
Saphnelo (anifrolumab-fnia)  
Selarsdi (ustekinumab-aekn)  
Siliq (brodalumab)  
Simlandi (adalimumab-ryvk)  
Simponi (golimumab)  
Simponi ARIA (golimumab)  
Skyrizi (risankizumab-rzaa)

**Contraindicated as Concomitant Therapy**

Sotyktu (deucravacitinib)  
Spevigo (spesolimab-sbzo) subcutaneous injection  
Starjemza (ustekinumab-hmny)  
Stelara (ustekinumab)  
Steqeyma (ustekinumab-stba)  
Taltz (ixekizumab)  
Tezspire (tezepelumab-ekko)  
Tofidence (tocilizumab-bavi)  
Tremfya (guselkumab)  
Truxima (rituximab-abbs)  
Tyenne (tocilizumab-aazg)  
Tyruko (natalizumab-sztn)  
Tysabri (natalizumab)  
Ustekinumab  
Velsipity (etrasimod)  
Wezlana (ustekinumab-auub)  
Xeljanz (tofacitinib)  
Xeljanz XR (tofacitinib extended release)  
Xolair (omalizumab)  
Yesintek (ustekinumab-kfce)  
Yuflyma (adalimumab-aaty)  
Yusimry (adalimumab-aqvh)  
Zeposia (ozanimod)  
Zymfentra (infliximab-dyyb)