Pharmacy Drug Policy Checklist

POLICY NAME	Opzelura (ruxolitinib)	POLICY #	3121P

Criteria

Coverage Criteria for Atopic Dermatitis

- ☐ **1.1** Diagnosis of mild to moderate atopic dermatitis
- ☐ **1.2** Age 12 years or older
- ☐ **1.3** Prescribed by or in consultation with a dermatologist (skin doctor), allergist (allergy doctor), or immunologist (immune system doctor)
- ☐ **1.4** Documented trial and failure or contraindication to topical corticosteroids, OR
  - Contraindication to topical steroids include: ☐ Treatment of sensitive areas (face, anogenital, skin folds) ☐ Steroid induced atrophy ☐ Long-term uninterrupted use
- ☐ **1.5** Documented trial and failure or contraindication to a topical calcineurin inhibitor (Tacrolimus ointment or Elidel cream)
  - Contraindication to topical calcineurin inhibitors include: ☐ Severely impaired skin barrier (Netherton Syndrome) ☐ Risk/Presence of malignancy

Coverage Criteria for Nonsegmental Vitiligo

- ☐ **2.1** Diagnosis of nonsegmental vitiligo
- ☐ **2.2** Total affected BSA does not exceed 10%
- ☐ **2.3** Other causes of depigmentation (lightening of skin) have been ruled out
- ☐ **2.4** Age 12 years or older
- ☐ **2.5** Prescribed by or in consultation with a dermatologist (skin doctor)
- ☐ **2.6** Documented trial and failure, intolerance or contraindication to one of the following:
  - Phototherapy
  - Oral immunosuppressant
  - Topical corticosteroid or calcineurin inhibitor