**STATE OF WEST VIRGINIA**
**DEPARTMENT OF HEALTH AND HUMAN RESOURCES**
**BUREAU FOR MEDICAL SERVICES**

**Office of Pharmacy Services**
**Prior Authorization Criteria**
**Opzelura®**
(*Ruxolitinib*)
**Effective 2/16/2022**

**Prior Authorization Request Form**

***Opzelura (Ruxolitinib)*** *is a topical Janus Kinase (JAK) Inhibitor indicated for short-term and noncontinuous chronic treatment of mild to moderate atopic dermatitis in immunocompetent patients ≥12 years of age whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable.*

**CRITERIA FOR APPROVAL:**

1- Patient has a diagnosis of mild to moderate atopic dermatitis; **AND**

2- The patient is within the age range as recommended by the FDA label; **AND**

3- Prescribed by, or in consultation with, an allergist, immunologist, or dermatologist; **AND**

4- The affected body surface area is ≤20%; **AND**

5- The patient has had an inadequate treatment response, intolerance, or contraindication after a minimum of 30-day trials of each of the following:

   a. A medium to high potency topical corticosteroid*,
   b. Pimecrolimus or tacrolimus,
   c. Eucrisa (for mild atopic dermatitis) and Dupixent (for moderate atopic dermatitis).

*Trial of medium to high potency topical steroid is required unless the affected area involves sensitive areas such as the face, skin folds or genitals.

6- Opzelura will **NOT** be approved for use in combination with therapeutic biologics, other JAK inhibitors, or potent immunosuppressants such as azathioprine or cyclosporine.

**Approval Duration**: Approval will be for 8 weeks.

***NOTE*:** **"The use of pharmaceutical samples will not be considered when evaluating the members' medical condition or prior prescription history for drugs that require prior authorization."**

**References:**


1.) Opzelura Package Insert
2.) Lexi-Comp Clinical Application 2/2022
3.) UpToDate Clinical monograph: Treatment of atopic dermatitis (eczema) reviewed 2/2022