BlueCross BlueShield of North Carolina

OPZELURA – Essential & Net Results

PRIOR REVIEW/CERTIFICATION FAXBACK FORM

INCOMPLETE FORMS MAY DELAY PROCESSING

ALL NC PROVIDERS MUST PROVIDE THEIR 5-DIGIT Blue Cross NC PROVIDER ID# BELOW

PRESCRIBER NAME	PRESCRIBER NPI [REQUIRED]	Blue Cross NC PROV ID # / TAX ID [out of state]

CONTACT PERSON	PRESCRIBER PHONE	PRESCRIBER FAX

PRESCRIBER ADDRESS	CITY	STATE	ZIP

PATIENT NAME	Blue Cross NC ID	DATE OF BIRTH	GENDER
			M F

Diagnosis Code: _____

Please answer the following questions for <u>INITIAL</u> coverage:

*See page 3 for continuation coverage

1. Is the patient 12 years of age or older?..... ☐ Yes ☐ No
2. Does the patient have a diagnosis of mild to moderate **atopic dermatitis**?..... ☐ Yes ☐ No
   IF YES, please answer the following questions:
   a. Does the patient have an affected body surface area (BSA) of less than or equal to 20%?..... ☐ Yes ☐ No
   b. Has the patient tried and failed at least one medium to high potency topical corticosteroid?..... ☐ Yes ☐ No
      i. **IF NO,** does the patient have a clinical intolerance/contraindication to ALL topical corticosteroids?..... ☐ Yes ☐ No
   c. Has the patient tried and failed at least one topical calcineurin inhibitor (e.g., tacrolimus ointment, etc)?..... ☐ Yes ☐ No
      i. **IF NO,** does the patient have a clinical intolerance/contraindication to ALL topical calcineurin inhibitors?..... ☐ Yes ☐ No
   d. Has the patient tried and failed a topical phosphodiesterase 4 (PDE4) inhibitor (e.g., Eucrisa)?..... ☐ Yes ☐ No
      i. **IF NO,** does the patient have a clinical intolerance/contraindication to ALL phosphodiesterase 4 (PDE4) inhibitors?..... ☐ Yes ☐ No
3. Does the patient have a diagnosis of **nonsegmental vitiligo**?..... ☐ Yes ☐ No
   IF YES, please answer the following questions:
   a. Does the patient have an affected body surface area (BSA) of less than or equal to 10%?..... ☐ Yes ☐ No
   b. Has the patient tried and failed at least one medium to high potency topical corticosteroid?..... ☐ Yes ☐ No
      i. **IF NO,** does the patient have a clinical intolerance/contraindication to ALL topical corticosteroids?..... ☐ Yes ☐ No
         A. **IF NO,** please provide information why the patient cannot use at least a medium potency topical steroid for the treatment of vitiligo: _____
         _____

****PLEASE NOTE: Continued on page 2, please complete and sign **page 2** for prior authorization request****

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OPZELURA – Essential & Net Results (*continued*)

Nonsegemental vitiligo *(continued)*

c. Has the patient tried and failed at least one topical calcineurin inhibitor (e.g., tacrolimus ointment, etc)?.....☐ Yes ☐ No

i. **IF NO,** does the patient have a clinical intolerance/contraindication to ALL topical calcineurin inhibitors?.....☐ Yes ☐ No

4. Will the patient be using the requested medication in combination with other biologic immunomodulators, JAK inhibitors, or potent immunosuppressants?.....☐ Yes ☐ No

5. Please list previously tried and failed medications for this diagnosis *(omission of information indicates N/A or none)*: _____
_____

6. Please list any medications the member has a contraindication or is intolerant to for this diagnosis *(omission of information indicates N/A or none)*: _____
_____

****PLEASE NOTE: If you are prescribing more than the program quantity limit (60 grams per 30 days), please complete and sign* **page 4*******

Please certify the following by signing and dating below:
I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time in order to verify this information. I further understand that if Blue Cross NC determines this information is not reflected in my patient's medical records, Blue Cross NC may request a refund of any payments made and/or pursue any other remedies available.
Prescriber's Signature (Required):_____ **Date**:_____

For Blue Cross NC members, fax form to 1-800-795-9403

BlueCross BlueShield of North Carolina

OPZELURA – Essential & Net Results - CONTINUATION

PRIOR REVIEW/CERTIFICATION FAXBACK FORM

INCOMPLETE FORMS MAY DELAY PROCESSING

ALL NC PROVIDERS MUST PROVIDE THEIR 5-DIGIT Blue Cross NC PROVIDER ID# BELOW

PRESCRIBER NAME	PRESCRIBER NPI [REQUIRED]	Blue Cross NC PROV ID # / TAX ID [out of state]	
CONTACT PERSON	PRESCRIBER PHONE	PRESCRIBER FAX	
PRESCRIBER ADDRESS	CITY	STATE	ZIP
PATIENT NAME	Blue Cross NC ID	DATE OF BIRTH	GENDER M F

Diagnosis Code: _____

Please answer the following questions for <u>CONTINUATION</u> coverage:

1. Was the patient approved for initial coverage for the requested medication through Blue Cross NC?.....☐ Yes ☐ No
   IF NO, please answer all questions on pages 1 and 2. IF YES, please answer the following questions:
2. Does the patient have a diagnosis of mild to moderate **atopic dermatitis**?.....☐ Yes ☐ No
   IF YES, please answer the following questions:
   a. Does the patient have an affected body surface area (BSA) of less than or equal to 20%?.....☐ Yes ☐ No
   b. Has the patient demonstrated a positive clinical response while using the medication, as demonstrated by improved skin clearance (i.e., improved IGA-TS score, a reduction in itching, rashes, inflammation, or dryness/scaling, etc.)?.....☐ Yes ☐ No
3. Does the patient have a diagnosis of **nonsegmental vitiligo**?.....☐ Yes ☐ No
   IF YES, please answer the following questions:
   a. Does the patient have an affected body surface area (BSA) of less than or equal to 10%?.....☐ Yes ☐ No
   b. Has the patient demonstrated a positive clinical response while using the medication, as demonstrated by a reduction in vitiligo patches or degree of depigmentation within patches (i.e., improved VASI or F-VASI score, etc.)?.....☐ Yes ☐ No
4. Will the patient be using the requested medication in combination with other biologic immunomodulators, JAK inhibitors, or potent immunosuppressants?.....☐ Yes ☐ No

**** NOTE: If you are prescribing more than the program quantity limit (60 grams per 30 days), please complete & sign* **page 4*******

Please certify the following by signing and dating below:
I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time in order to verify this information. I further understand that if Blue Cross NC determines this information is not reflected in my patient's medical records, Blue Cross NC may request a refund of any payments made and/or pursue any other remedies available.
Prescriber's Signature (Required):_____ **Date**:_____

For Blue Cross NC members, fax form to 1-800-795-9403

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COMPLETE PAGE 4 ONLY IF REQUESTING A QUANTITY LIMIT EXCEPTION FOR OPZELURA

PRESCRIBER NAME	PRESCRIBER NPI [REQUIRED]	Blue Cross NC PROV ID # / TAX ID [out of state]
CONTACT PERSON	**PRESCRIBER PHONE**	**PRESCRIBER FAX**
PRESCRIBER ADDRESS	**CITY**	**STATE** **ZIP**
PATIENT NAME	**Blue Cross NC ID**	**DATE OF BIRTH** **GENDER**
		M F

FOR COVERAGE OVER THE QUANTITY LIMITS (MAXIMUM PROGRAM LIMITS) LISTED BELOW, PLEASE ANSWER THE FOLLOWING:

Please note: This medication requires a prior authorization before a quantity limit override can be considered. Before submitting a request for a quantity level override, please ensure that a prior approval authorization has been submitted and/or approved (pages 1-2 or page 3). Otherwise, this request will deny.

Diagnosis Code:_____

Medication	Quantity
Opzelura (ruxolotinib) cream 1.5%	60 grams per 30 days

Requested Quantity per 30 days: _____ **grams**
****Please enter quantity as a numeric value with one decimal place (ex. 1.0, 1.5)****

In the space provided, please document support for the requested Quantity Limit Exception (this may include documented clinical rationale and/or medical records). **Rationale must be submitted.**

_____

_____

_____

Please certify the following by signing and dating below:
I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time in order to verify this information. I further understand that if Blue Cross NC determines this information is not reflected in my patient's medical records, Blue Cross NC may request a refund of any payments made and/or pursue any other remedies available.
Prescriber's Signature (Required):_____ **Date**:_____

For Blue Cross NC members, fax form to 1-800-795-9403