CAREFIRST VA

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 855-582-2038 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Patient Information

Patient Name:

Patient Phone: ☐☐☐-☐☐☐-☐☐☐☐

Patient ID:

Patient Group:

Patient DOB: ☐☐/☐☐/☐☐☐☐

Physician Information

Physician Name

Physician Phone: ☐☐☐-☐☐☐-☐☐☐☐

Physician Fax: ☐☐☐-☐☐☐-☐☐☐☐

Physician Addr.:

City, St, Zip:

Drug Name (select from list of drugs shown)

Opzelura (ruxolitinib cream)

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

_____

Please check the appropriate answer for each applicable question.

1.	Is this request for continuation of therapy?	**Y** ☐	**N** ☐
2.	Has the patient achieved or maintained positive clinical response as evidenced by improvement [e.g., improvement in or resolution of any of the following signs and symptoms: erythema (redness), exudation (oozing and crusting), excoriation (evidence of scratching), induration (hardening)/papulation (formation of papules), lichenification (epidermal thickening), OR pruritus (itching)]?	**Y** ☐	**N** ☐
3.	Is the requested drug being prescribed for the topical short-term and non-continuous chronic treatment of mild to moderate atopic dermatitis in a non-immunocompromised patient 12 years of age or older?	**Y** ☐	**N** ☐
4.	Will the requested drug be used on sensitive skin areas (e.g., face, genitals or skin folds)?	**Y** ☐	**N** ☐
5.	Has the patient experienced an inadequate treatment response, intolerance, or contraindication to a topical calcineurin inhibitor?	**Y** ☐	**N** ☐
6.	Has the patient experienced an inadequate treatment response, intolerance or contraindication to a topical calcineurin inhibitor AND a medium or higher potency topical corticosteroid?	**Y** ☐	**N** ☐
7.	On what percentage of the patient's body surface area (BSA) will the requested drug be applied?		
	4 percent or less of body surface area (BSA) (if checked, go to 8)	☐	
	Greater than 4 percent and up to 8 percent of body surface area (BSA) (if checked, go to 9)	☐	

Greater than 8 percent and up to 12 percent of body surface area (BSA) (if checked, go to 10) ☐

Greater than 12 percent and up to 16 percent of body surface area (BSA) (if checked, go to 11) ☐

Greater than 16 percent of body surface area and up to 20 percent of body surface area (BSA) (if checked, go to 12) ☐

Greater than 20 percent of body surface area (if checked, no further questions) ☐

8. Does the patient require MORE than 60 grams per month? **Y** ☐ **N** ☐

9. Does the patient require MORE than 120 grams per month? **Y** ☐ **N** ☐

10. Does the patient require MORE than 180 grams per month? **Y** ☐ **N** ☐

11. Does the patient require MORE than 240 grams per month? **Y** ☐ **N** ☐

12. Does the patient require MORE than 300 grams per month? **Y** ☐ **N** ☐

13. On what percentage of the patient's body surface area (BSA) will the requested drug be applied?

4 percent or less of body surface area (BSA) (if checked, go to 14) ☐

Greater than 4 percent and up to 8 percent of body surface area (BSA) (if checked, go to 15) ☐

Greater than 8 percent and up to 12 percent of body surface area (BSA) (if checked, go to 16) ☐

Greater than 12 percent and up to 16 percent of body surface area (BSA) (if checked, go to 17) ☐

Greater than 16 percent of body surface area and up to 20 percent of body surface area (BSA) (if checked, go to 18) ☐

Greater than 20 percent of body surface area (if checked, no further questions) ☐

14. Does the patient require MORE than 60 grams per month? **Y** ☐ **N** ☐

15. Does the patient require MORE than 120 grams per month? **Y** ☐ **N** ☐

16. Does the patient require MORE than 180 grams per month? **Y** ☐ **N** ☐

17. Does the patient require MORE than 240 grams per month? **Y** ☐ **N** ☐

18. Does the patient require MORE than 300 grams per month? **Y** ☐ **N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date