STATE OF WEST VIRGINIA
DEPARTMENT OF HUMAN SERVICES
BUREAU FOR MEDICAL SERVICES

Alex J. Mayer
Cabinet Secretary

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Commissioner

Office of Pharmacy Services
Prior Authorization Criteria
Opzelura®
(*Ruxolitinib*)
Effective 11/13/2024
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 must be within the age range as recommended by the Food and Drug Administration (FDA) label and indication; **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**

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

*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.

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."