AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Litfulo™ (ritlecitinib)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: ______________________________

Member AvMed #: ______________________ **Date of Birth:** ____________

Prescriber Name: ______________________________

Prescriber Signature: ______________________ **Date:** ____________

Office Contact Name: ______________________________

Phone Number: ____________________ **Fax Number:** ____________________

DEA OR NPI #: ______________________________

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: ______________________________

Dosing Schedule: ____________________ **Length of Therapy**: ____________________

Diagnosis: ____________________ **ICD Code, if applicable:** ____________________

Weight: ____________________ **Date:** ____________________

Quantity Limit: 1 capsule per day

NOTE: The Health Plan considers the use of concomitant therapy with more than one biologic immunomodulator (e.g., Dupixent, Olumiant, Xeljanz IR/XR) prescribed for the same or different indications to be experimental and investigational. Safety and efficacy of these combinations has **NOT** been established and will **NOT** be permitted.

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member is 12 years of age or older
- ❑ Prescribed by or in consultation with a **Dermatologist**
- ❑ Member has a diagnosis of **alopecia areata**
- ❑ Member has ≥ 50% of scalp hair loss measured by the Severity of Alopecia Tool (SALT) for more than 6 months **(chart notes with documentation of SALT score must be submitted)**

(Continued on next page)

- ❑ Member does **NOT** have hair loss due to other forms of alopecia (i.e., androgenetic alopecia, chemotherapy induced, trichotillomania, telogen effluviums, and systemic lupus erythematosus)
- ❑ Member has experienced treatment failure, has a contraindication or intolerance to **ONE** of the following therapies used for at least **three (3) months** **(chart notes documenting treatment failure must be submitted)**:
  - ❑ Oral corticosteroids (e.g., prednisone)
  - ❑ Oral immunosuppressants (e.g., azathioprine, cyclosporine, methotrexate)
  - ❑ Intralesional corticosteroids (e.g., triamcinolone acetonide 5-10 mg/mL)
  - ❑ Topical immunotherapy treatment (e.g., Squaric Acid Dibutyl Ester – SADBE; Diphenylcyclopropenone – DPCP)
- ❑ Member is **NOT** receiving Litfulo™ in combination with other JAK inhibitors, biologic immunomodulators, or with other potent immunosuppressants

Medication being provided by Specialty Pharmacy – Proprium Rx

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****