

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 Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Weight: _____ **Date:** _____

Quantity Limit: 1 capsule per day

NOTE: AvMed 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 $\geq 50\%$ 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 must meet **ONE** of the following:
 - ❑ Member has a documented inadequate response, contraindication, or intolerance to topical immunotherapy treatment (i.e., Squaric Acid Dibutyl Ester – SADBE; Diphenylcyclopropenone – DPCP) for at least **six (6) months** (chart notes documenting treatment failure must be submitted)
 - ❑ Member has experienced treatment failure, has a contraindication or intolerance to **TWO** 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)
 - ❑ Medium to high potency topical corticosteroids (e.g., mometasone, triamcinolone)

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.****