Pharmacy Drug Policy & Procedure

Policy Name:	Opzelura (ruxolitinib)	Policy#:	3121P

Purpose of the Policy

The purpose of this policy is to define coverage criteria for Opzelura (ruxolitinib).

Statement of the Policy

Health Alliance Medical Plans and Health Alliance Northwest will approve the use of Opzelura (ruxolitinib) under the specialty pharmacy benefit if the following criteria are met.

Criteria

1. Coverage Criteria for Atopic Dermatitis

1.1 Diagnosis of mild to moderate atopic dermatitis
1.2 Age 12 years or older
1.3 Prescribed by or in consultation with a dermatologist (skin doctor), allergist (allergy doctor), or immunologist (immune system doctor)
1.4 Documented trial and failure or contraindication to topical corticosteroids, OR
- Contraindication to topical steroids include:
  - Treatment of sensitive areas (face, anogenital, skin folds)
  - Steroid induced atrophy
  - Long-term uninterrupted use

1.5 Documented trial and failure or contraindication to a topical calcineurin inhibitor (Tacrolimus ointment or Elidel cream)
- Contraindication to topical calcineurin inhibitors include:
  - Severely impaired skin barrier (Netherton Syndrome)
  - Risk/Presence of malignancy

2. Coverage Criteria for Nonsegmental Vitiligo

2.1 Diagnosis of nonsegmental vitiligo
2.2 Total affected BSA does not exceed 10%
2.3 Other causes of depigmentation (lightening of skin) have been ruled out
2.4 Age 12 years or older
2.5 Prescribed by or in consultation with a dermatologist (skin doctor)
2.6 Documented trial and failure, intolerance or contraindication to one of the following:
- Phototherapy
- Oral immunosuppressant
- Topical corticosteroid or calcineurin inhibitor

3. Exclusion Criteria

3.1 Opzelura will not be covered if used in combination with other systemic atopic dermatitis therapies

4. Approval Period

4.1 Initial: 12 months
4.2 Subsequent Approvals: 12 months with documentation of positive response to therapy

CPT Codes

HCPCS Codes	

References

1. Opzelura (ruxolitinib) [prescribing information]. Wilmington, DE: Incyte Corporation; January 2023.
2. AAAAI/ACAAI JTF Atopic Dermatitis Guideline Panel; Chu DK, Schneider L, Asiniwasis RN, et al. Atopic dermatitis (eczema) guidelines: 2023 American Academy of Allergy, Asthma and Immunology/American College of Allergy, Asthma and Immunology Joint Task Force on Practice Parameters GRADE- and Institute of Medicine-based recommendations. Ann Allergy Asthma Immunol. 2024 Mar;132(3):274-312.
3. Seneschal J, Speeckaert R, Taïeb A, et al. Worldwide expert recommendations for the diagnosis and management of vitiligo: Position statement from the international Vitiligo Task Force-Part 2: Specific treatment recommendations. J Eur Acad Dermatol Venereol. 2023 Nov;37(11):2185-2195.

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DISCLAIMER
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