Nevada Medicaid

Submit fax request to: 855-455-3303

Please note: All information below is required to process this request.

Opzelura® (ruxolitinib) Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED.

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if request is for initial trial ❑ Check if request is for recertification of therapy	Directions for Use:	

Clinical Information (required)

Authorization:

- ❑ The recipient has a diagnosis of mild to moderate atopic dermatitis
- ❑ The recipient is 12 years of age or older
- ❑ The medication will not be used chronically
- ❑ The recipient is not immunocompromised
- ❑ ONE of the following:
  - Disease is not adequately controlled with other topical prescription therapies
  - Other topical prescription therapies are not advised for the patient

Attach any additional comments, diagnoses, symptoms, medications tried or failed, or other information the physician feels is important to this review.

Please note: This request may be denied unless all required information is received. For urgent or expedited requests please call 1-800-711-4555. This form may be used for non-urgent requests and faxed to 1-800-527-0531.