PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

2/20/2026

Prior Authorization

Internal Use Only

JOHNS HOPKINS HEALTH PLANS

Opzelura - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**.
Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Opzelura - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Opzelura (ruxolitinib)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Will the requested medication be used for any indications that are not Food and Drug Administration (FDA)-approved or guideline-supported? Y N

[If yes, no further questions.]

2.	Does the patient have any of the following: A) Immunocompromised status, B) Active, serious infection, including localized infections, C) Active hepatitis B or hepatitis C infection, D) Long-term, continuous treatment for atopic dermatitis (AD), E) Concurrent use with biologics, other Janus kinase (JAK) inhibitors, or potent immunosuppressants, such as azathioprine or cyclosporine?	Y N
	[If yes, no further questions.]	
3.	Is the patient less than 2 years of age?	Y N
	[If yes, no further questions.]	
4.	Has the plan authorized the requested medication in the past for this patient (i.e., previous authorization is on file under this plan)?	Y N
	NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.	
	[If no, skip to question 8.]	
5.	Does the patient have a diagnosis of mild to moderate atopic dermatitis (AD)?	Y N
	[If yes, no further questions.]	
6.	Does the patient have a diagnosis of Vitiligo?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
7.	Has the patient experienced meaningful repigmentation as a result of treatment?	Y N
	NOTE: Submission of medical records is required.	
	[No further questions.]	
8.	Does the patient have a diagnosis of mild to moderate atopic dermatitis (AD)?	Y N
	NOTE: Submission of medical records is required.	
	[If no, skip to question 14.]	
9.	Is the patient 2 years of age or older?	Y N
	[If no, no further questions.]	
10.	Will the requested medication be used for short-term treatment?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
11.	Does the patient have an affected Body Surface Area (BSA) of 3% to 20%?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	

12. Has a baseline assessment been completed using one of the following tools: A) Investigator's Static Global Assessment (ISGA) score, B) Eczema Area and Severity Index (EASI), C) Patient-Oriented Eczema Measure (POEM), D) Scoring Atopic Dermatitis (SCORAD) index?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
13. Has the patient tried and experienced inadequate response, or does the patient have a contraindication to all of the following: A) One or more formulary topical corticosteroids, B) One topical calcineurin inhibitor (pimecrolimus [Elidel] or tacrolimus [Protopic]), C) Eucrisa (crisaborole)?	Y N	
NOTE: Submission of medical records is required.		
[No further questions.]		
14. Does the patient have a diagnosis of nonsegmental vitiligo?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
15. Is the patient 12 years of age or older?	Y N	
[If no, no further questions.]		
16. Does the patient have an affected Body Surface Area (BSA) less than or equal to 10%?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
17. Has the patient tried and experienced inadequate response, or does the patient have a contraindication to both of the following: A) One or more formulary topical corticosteroids, B) One topical calcineurin inhibitor (pimecrolimus [Elidel] or tacrolimus [Protopic])?	Y N	
NOTE: Submission of medical records is required.		

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date