BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

PHARMACY COVERAGE GUIDELINES
SECTION: DRUGS

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OPZELURA™ (ruxolitinib) cream

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Pharmacy Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.

This Pharmacy Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide BCBSAZ complete medical rationale when requesting any exceptions to these guidelines.

The section identified as "Description" defines or describes a service, procedure, medical device or drug and is in no way intended as a statement of medical necessity and/or coverage.

The section identified as "Criteria" defines criteria to determine whether a service, procedure, medical device or drug is considered medically necessary or experimental or investigational.

State or federal mandates, e.g., FEP program, may dictate that any drug, device or biological product approved by the U.S. Food and Drug Administration (FDA) may not be considered experimental or investigational and thus the drug, device or biological product may be assessed only on the basis of medical necessity.

Pharmacy Coverage Guidelines are subject to change as new information becomes available.

For purposes of this Pharmacy Coverage Guideline, the terms "experimental" and "investigational" are considered to be interchangeable.

This Pharmacy Coverage Guideline does not apply to FEP or other states' Blues Plans.

Information about medications that require precertification is available at www.azblue.com/pharmacy.

Some large (100+) benefit plan groups may customize certain benefits, including adding or deleting precertification requirements.

All applicable benefit plan provisions apply, e.g., waiting periods, limitations, exclusions, waivers and benefit maximums.

Precertification for medication(s) or product(s) indicated in this guideline requires completion of the request form in its entirety with the chart notes as documentation. **All requested data must be provided.** Once completed the form must be signed by the prescribing provider and faxed back to BCBSAZ Pharmacy Management at (602) 864-3126 or emailed to Pharmacyprecert@azblue.com. **Incomplete forms or forms without the chart notes will be returned.**

OPZELURA™ (ruxolitinib) cream

Criteria:

- **Criteria for initial therapy:** Opzelura (ruxolitinib) cream is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

1. Prescriber is a physician specializing in the patient's diagnosis or is in consultation with a Dermatologist

2. Individual is 12 years of age or older

3. A confirmed diagnosis of short-term and non-continuous chronic treatment of mild to moderate atopic dermatitis in a non-immune compromised individual who is not adequately controlled with topical prescription therapies or when these therapies are not advisable

4. **ALL** of the following **baseline tests** have been completed before initiation of treatment with continued monitoring as clinically appropriate:
    a. Affected area **is less than** 20% of body surface area
    b. Intensity of pruritus is described as moderate [See Definition section]
    c. Appearance of lesions are described as mild or moderate [See Definition section]

5. **ONE** of the following:
    a. **For eyelids, face, neck intertriginous and genital areas**:
        i. Failure, contraindication per FDA label, intolerance, or not a candidate for **BOTH** of the following selected based on severity of disease and age of patient :
            1. Topical calcineurin inhibitor, such as pimecrolimus (generic or brand Elidel) **or** tacrolimus (generic or brand Protopic)

            2. Eucrisa (crisaborole)

    b. **For all other body areas**:
        i. **For mild disease:** Failure, contraindication per FDA label, intolerance, or not a candidate for **two** low potency corticosteroids (such as desonide 0.05%, fluocinolone acetonide 0.01%, and others)

        ii. **For moderate disease:** Failure, contraindication per FDA label, intolerance, or not a candidate for **two** medium to high potency corticosteroids (such as triamcinolone acetonide 0.1%, mometasone furoate 0.1%, betamethasone dipropionate 0.05%, desoximetasone 0.05%, and others)

6. Will not be used in combination with therapeutic biologics, other JAK inhibitors or potent immune suppressing agents such as azathioprine or cyclosporine

7. Individual does not have an active, serious infection, including localized infections

8. Individual does not have active hepatitis B or hepatitis C

9. There are no significant interacting drugs

Initial approval duration: 2 months

- **Criteria for continuation of coverage (renewal request):** Opzelura (ruxolitinib) cream is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

1. Individual continues to be seen by a physician specializing in the patient's diagnosis or is in consultation with a Dermatologist

2. Individual's condition has responded while on therapy
    a. Response is defined as:
        i. No evidence of disease progression
        ii. Intensity of pruritus is described as decreased to mild or change in itch score of at least 4 over baseline
        iii. Appearance of lesions are described as clear or almost clear
        iv. No evidence individual has developed any significant unacceptable adverse drug reactions that may exclude continued use

3. Individual has been adherent with the medication

4. Individual has not developed any contraindications or other significant adverse drug effects that may exclude continued use
    a. Significant adverse effect such as:
        i. Active serious infection
        ii. Thrombosis, including deep venous thrombosis, pulmonary embolism, and arterial thrombosis
        iii. Thrombocytopenia, anemia, or neutropenia

5. Affected area **is less than** 20% of body surface area

6. Will not be used in combination with therapeutic biologics, other JAK inhibitors or potent immune suppressing agents such as azathioprine or cyclosporine

7. Individual does not have an active, serious infection, including localized infections

8. Individual does not have active hepatitis B or hepatitis C

9. There are no significant interacting drugs

Renewal duration: 3 months

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- Criteria for a request for non-FDA use or indication, treatment with dosing, frequency, or duration outside the FDA-approved dosing, frequency, and duration, refer to one of the following Pharmacy Coverage Guideline:

  1. **Off-Label Use of a Non-cancer Medications**

  2. **Off-Label Use of a Cancer Medication for the Treatment of Cancer without a Specific Coverage Guideline**

Description:

Opzelura (ruxolitinib) cream is a Janus kinase (JAK) inhibitor indicated for the topical short-term and non-continuous chronic treatment of mild to moderate atopic dermatitis in non-immunocompromised patients 12 years of age and older whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable. Use of Opzelura (ruxolitinib) cream in combination with therapeutic biologics, other JAK inhibitors or potent immunosuppressants such as azathioprine or cyclosporine is not recommended.

Ruxolitinib inhibits JAK1 and JAK2 which mediate the signaling of several cytokines and growth factors that are important for hematopoiesis and immune function. JAK signaling involves recruitment of STATs (signal transducers and activators of transcription) to cytokine receptors, activation and subsequent localization of STATs to the nucleus leading to modulation of gene expression. The relevance of inhibition of specific JAK enzymes to therapeutic effectiveness is not currently known.

The diagnosis of atopic dermatitis is based on clinical symptoms. There is no optimal long-term maintenance treatment and there is no known cure. In general, treatment involves elimination of exacerbating factors, restoring the skin's barrier function, hydrating the skin and use of topical anti-inflammatory agents. Patients with atopic dermatitis should avoid exacerbating factors including excessive bathing, low humidity environments, emotional stress, xerosis, and exposure to detergents. Thick creams with low water content or ointments which have zero water content protect against xerosis and should be utilized. Antihistamines are utilized as an adjunct in patients with atopic dermatitis to control pruritus and eye irritation. Sedating antihistamines such as diphenhydramine or hydroxyzine appear to be more effective than non-sedating agents.

Treatment of atopic dermatitis initially involves use of topical prescription therapies such as corticosteroids, calcineurin inhibitors (tacrolimus ointment, pimecrolimus cream) and topical phosphodiesterase 4 (PDE-4) inhibitors (crisaborole ointment). Topical corticosteroids are considered the standard of care; strength and formulation of the preparation is selected based on severity, duration of treatment, location of exacerbation, and age of individual. Topical calcineurin and topical PDE-4 inhibitors should be reserved for problem areas only, such as the face, neck, intertriginous and genital areas.

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Definitions:

Diagnostic criteria for atopic dermatitis: (*Diagnosis requires the presence of at least **3** major & **3** minor criteria)*

Major criteria
Pruritus
Dermatitis affecting flexural surfaces in adults and the face and extensors in infants
Chronic or relapsing dermatitis
Personal or family history of cutaneous or respiratory atopy
Minor criteria
Features of the so-called "atopic facies"
Facial pallor or erythema
Hypopigmented patches
Infraorbital darkening
Infraorbital folds or wrinkles
Cheilitis
Recurrent conjunctivitis
Anterior neck folds
Triggers of atopic dermatitis
Foods
Emotional factors
Environmental factors
Skin irritants such as wool, solvents and sweat
Complications of atopic dermatitis
Susceptibility to cutaneous viral and bacterial infections
Impaired cell-mediated immunity
Immediate skin-test reactivity
Raised serum IgE
Keratoconus
Anterior subcapsular cataracts
Others

Early age of onset
Dry skin
Ichthyosis
Hyperlinear palms
Keratosis pilaris (plugged hair follicles of proximal extremities)
Hand and foot dermatitis
Nipple eczema
White dermatographism
Perifollicular accentuation

Adapted from: Hanifin JM, Rajka G, Acta Dermatol Venereol 1980; 92(Suppl):44.

Investigator Global Assessment Scale (IGA):
Validated-Investigator-Global-Assessment-Scale_vIGA-AD_2017.pdf (eczemacouncil.org) [Accessed October 09, 2021]

The IGA score is selected using the morphologic descriptors that best describe the overall appearance of the lesions at a given time point. It is not necessary that all characteristics under Morphological Description be present.

Score	Morphological Description
0 – Clear	No inflammatory signs of atopic dermatitis (no erythema, no induration/papulation, no lichenification, no oozing/crusting). Post-inflammatory hyperpigmentation and/or hypopigmentation may be present.
1 – Almost clear	Barely perceptible erythema, barely perceptible induration/papulation, and/or minimal lichenification. No oozing or crusting.
2 – Mild	Slight but definite erythema (pink), slight but definite induration/papulation, and/or slight but definite lichenification. No oozing or crusting.
3 – Moderate	Clearly perceptible erythema (dull red), clearly perceptible induration/papulation, and/or clearly perceptible lichenification. Oozing and crusting may be present.
4 – Severe	Marked erythema (deep or bright red), marked induration/papulation, and/or marked lichenification. Disease is widespread in extent. Oozing or crusting may be present.
Notes: 1. In indeterminate cases, use extent to differentiate between scores. For example: • Patient with marked erythema (deep or bright red), marked papulation and/or marked lichenification that is limited in extent (instead of widespread), would be considered “3 – Moderate”. 2. Excoriations should not be considered when assessing disease severity	

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Pruritus Numerical Rating Scale (NRS):
Numerical Rating Scale - Pruritus Resources (pruritussymposium.de) [Accessed October 09, 2021]

The NRS is comprised of one item and is represented by numbers 0 (“no itch”) to 10 (“worst imaginable itch”). Patients are asked to rate the intensity of their itch using this scale. It features high reliability and concurrent validity and is a popular choice for all patients due to its simple format. Time needed for completion: 1 minute. It has been validated in several languages.

- It can be interpreted as follows:
  - NRS 0 - no pruritus
  - NRS < 3 - mild pruritus
  - NRS ≥ 3 < 7 - moderate pruritus
  - NRS ≥ 7 < 9 - severe pruritus
  - NRS ≥ 9 - very severe pruritus

On a scale from 0 (no itch) to 10 (worst imaginable itch), how would you rate your itch overall (on average) during the past 24-hour? (Select number)										
0	1	2	3	4	5	6	7	8	9	10

Resources:

Opzelura (ruxolitinib) cream product information, revised by Incyte Corporation 09-2021. Available at DailyMed http://dailymed.nlm.nih.gov. Accessed October 09, 2021.

Weston WL, Howe W. Atopic dermatitis (eczema): Pathogenesis, clinical manifestations, and diagnosis. In: UpToDate, Dellavalle RP, Levy ML, Fowler J, Corona R (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Accessed October 11, 2021.

Weston WL, Howe W. Treatment of atopic dermatitis (eczema). In: UpToDate, Dellavalle RP, Levy ML, Fowler J, Corona R (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Accessed October 11, 2021.

Spergel JM, Lio PA. Management of severe atopic dermatitis (eczema) in children. In: UpToDate, Dellavalle RP, Levy ML, Fowler J, Corona R (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Accessed October 11, 2021.

Berger TG. Evaluation and management of severe refractory atopic dermatitis (eczema)in adults. In: UpToDate, Fowler J, Levy ML, Dellavalle RP, Corona R (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Accessed October 11, 2021.