

## Litfulo (Ritlecitinib) Prior Authorization of Benefits Form

Texas | Medicaid

**CONTAINS CONFIDENTIAL PATIENT INFORMATION**

Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 844-474-3341.

**1. Patient information**

**2. Physician information**

Patient name: <hr/> Patient ID #: <hr/> Patient DOB: <hr/> Date of Rx: <hr/> Patient phone #: <hr/> Patient email address: <hr/>	Prescribing physician: <hr/> Physician address: <hr/> Physician phone #: <hr/> Physician fax #: <hr/> Physician specialty: <hr/> Physician DEA: <hr/> Physician NPI #: <hr/> Physician email address: <hr/>
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**3.**

**Medication**

**4. Strength**

**5. Directions**

**6. Quantity per 30 days**

Litfulo (Ritlecitinib)			Specify:
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**7. Diagnosis:**

**8. Approval criteria:** (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is the patient greater than or equal to ( $\geq$ ) 12 years of age
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the patient have a diagnosis of alopecia areata in the last 730 days?

[provider.wellpoint.com/tx](http://provider.wellpoint.com/tx)

Medicaid services provided by Wellpoint Insurance Company to members in the Medicaid Rural Service Area and the STAR Kids program and Wellpoint Texas, Inc. to all other Wellpoint members in Texas.

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Will the patient have concurrent therapy with a JAK inhibitor, biologic DMARD or potent immunosuppressant?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Will the patient have concurrent therapy with a strong CYP3A inducer?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the patient have a diagnosis of severe hepatic impairment in the last 365 days?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the patient have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the patient have a diagnosis that indicates increased risk of thrombosis or malignancy in the last 180 days?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Will the patient have concurrent therapy with another Cytokine and CAM antagonist?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is the requested dose less than or equal to ( $\leq$ ) 1 capsule daily?

For the *Texas Medicaid Preferred Drug List*, please refer to the Texas Medicaid Vendor Drug Program website at <https://www.txvendordrug.com/formulary/formulary-search>

**9. Physician signature**

_____	_____
Prescriber or authorized signature	Date
<i>Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.</i>	
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