



AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name: Opzelura

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Effective Date: 11/4/2025

Last Review Date: 10/16/2025

Applies to: Illinois
 Florida Kids

New Jersey
 Pennsylvania Kids

Maryland
 Virginia

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Opzelura under the patient's prescription drug benefit.

Description:

FDA-Approved Indication

Atopic Dermatitis

Opzelura is indicated for the topical short-term and non-continuous chronic treatment of mild to moderate atopic dermatitis in non-immunocompromised adult and pediatric patients 2 years of age and older whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable.

Nonsegmental Vitiligo

Opzelura is indicated for the topical treatment of nonsegmental vitiligo in adult and pediatric patients 12 years of age and older.

Limitations of Use

Use of Opzelura in combination with therapeutic biologics, other JAK inhibitors, or potent immunosuppressants such as azathioprine or cyclosporine is not recommended..

Applicable Drug List:

Opzelura

Policy/Guideline:

Criteria for Initial Approval:

For the indication of Atopic Dermatitis, the patient is unable to take the required formulary alternatives, Rinvoq and Eucrisa, due to a trial and inadequate treatment response, or intolerance, or a contraindication

Atopic Dermatitis

Authorization may be granted when the requested drug is being prescribed for topical short-term and non-continuous chronic treatment of mild to moderate atopic dermatitis in a non-immunocompromised patient when ALL the following criteria are met:

- The requested drug is NOT being prescribed in combination with therapeutic biologics, other janus kinase (JAK) inhibitors, or potent immunosuppressants such as azathioprine or cyclosporine.
- The request is for an adult or pediatric patient 2 years of age or older.
- The patient meets ONE of the following:



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- The patient's disease is NOT adequately controlled with other topical prescription therapies (e.g., medium or higher potency topical corticosteroid, topical calcineurin inhibitor).
- Other topical prescription therapies are NOT advisable (e.g., medium or higher potency topical corticosteroid, topical calcineurin inhibitor).
- The requested drug will NOT be applied to affected areas of greater than 20% body surface area (BSA).
- If additional quantities are being requested, then the requested drug is being prescribed to treat a body surface area that requires more than 60 grams per 28 days.

Nonsegmental Vitiligo

Authorization may be granted when the requested drug is being prescribed for nonsegmental vitiligo when ALL the following criteria are met:

- The requested drug is NOT being prescribed in combination with therapeutic biologics, other janus kinase (JAK) inhibitors, or potent immunosuppressants such as azathioprine or cyclosporine.
- The request is for an adult or pediatric patient 12 years of age or older.
- The requested drug will NOT be applied to affected areas of greater than 10% body surface area (BSA).
- If additional quantities are being requested, then the requested drug is being prescribed to treat a body surface area that requires more than 60 grams per 28 days.

Continuation of Therapy

Atopic Dermatitis

Authorization may be granted when the requested drug is being prescribed for topical short-term and non-continuous chronic treatment of mild to moderate atopic dermatitis in a non-immunocompromised patient when ALL the following criteria are met:

- The requested drug is NOT being prescribed in combination with therapeutic biologics, other janus kinase (JAK) inhibitors, or potent immunosuppressants such as azathioprine or cyclosporine.
- The request is for an adult or pediatric patient 2 years of age or older.
- The patient has achieved or maintained a positive clinical response as evidenced by improvement [(e.g., improvement in or resolution of ANY of the following signs and symptoms: erythema (redness), edema (swelling), xerosis (dry skin), erosions, excoriations (evidence of scratching), oozing and crusting, lichenification (epidermal thickening), OR pruritus (itching)].
- The requested drug will NOT be applied to affected areas of greater than 20% body surface area (BSA).
- If additional quantities are being requested, then the requested drug is being prescribed to treat a body surface area that requires more than 60 grams per 28 days.



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Nonsegmental Vitiligo

Authorization may be granted when the requested drug is being prescribed for nonsegmental vitiligo when ALL the following criteria are met:

- The requested drug is NOT being prescribed in combination with therapeutic biologics, other janus kinase (JAK) inhibitors, or potent immunosuppressants such as azathioprine or cyclosporine.
- The request is for an adult or pediatric patient 12 years of age or older.
- The patient has achieved or maintained a positive clinical response as evidenced by improvement (e.g., meaningful repigmentation).
- The requested drug will NOT be applied to affected areas of greater than 10% body surface area (BSA).
- If additional quantities are being requested, then the requested drug is being prescribed to treat a body surface area that requires more than 60 grams per 28 days.

Approval Duration and Quantity Restrictions:

- Nonsegmental Vitiligo
Initial therapy: 7 months
Continuation of therapy: 12 months
- Atopic Dermatitis
Initial therapy: 3 months
Continuation of therapy: 12 months

Quantity Level Limit:

- 60 grams per 28 days
- Vitiligo - for larger body surface area (BSA): 180 grams per 28 days.
- Atopic Dermatitis - for larger body surface area (BSA): Pediatric patients 2 to 11 years of age: 120 grams per 28 days.
- Atopic Dermatitis - for larger body surface area (BSA): Patients 12 years of age and older: 240 grams per 28 days.

References:

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