Louisiana Medicaid
Deuruxolitinib (Leqselvi™)

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request clinical authorization for deuruxolitinib (Leqselvi™).

Additional Point-of-Sale edits may apply.

By submitting the authorization request, the prescriber attests to the conditions available HERE.

When currently posted criteria are not met, a clinical reviewer will consider the most current FDA-approved prescribing information for the requested agent when evaluating the request.

General approval criteria (ALL criteria must be met):

- An appropriate diagnosis is required, and the agent must be prescribed according to U.S. Food and Drug Administration approved indications, dosing, safety and monitoring regulations; **AND**
- If the request is for a non-preferred agent, there is no preferred alternative that is:
  - The exact same chemical entity, formulation, strength, etc.; **OR**
  - An FDA-approved biosimilar to the requested medication that is indicated for the condition being treated; **AND**
- If request is for a non-preferred agent - **ONE** of the following is required: (See Pain Management – Cytokine and CAM Antagonists on the PDL/NPDL for list of preferred agents)
  - The recipient had documented *intolerable side effects* or a documented *treatment failure* with an adequate trial (6-12 weeks) of **TWO** preferred agents, if the preferred agents are indicated for the specified diagnosis; **OR**
  - The recipient has a *contraindication* to the preferred agents indicated for the specified diagnosis.

Approval criteria for specific diagnoses:

Alopecia Areata

- The recipient is 18 years of age or older on the date of the request; **AND**
- The following are true and is **stated on the request**:
  - The recipient has at least 50% scalp hair loss as measured by the Severity of Alopecia Tool (SALT) for more than 6 months; **AND**
  - The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a rheumatologist or dermatologist; **AND**
  - The agent is not being given in combination with other JAK inhibitors (e.g., tofacitinib), biologic DMARDS, or with potent immunosuppressants such as azathioprine and cyclosporine; **AND**
  - The recipient has an ANC (absolute neutrophil count) $\geq$ 1000/mm3, an ALC (absolute lymphocyte count) $\geq$ 500/mm3, and hemoglobin $\geq$ 8 g/dL.

Approval Criteria for Continuation of Therapy

- The prescriber **states on the request** that there is evidence of a positive response to treatment as indicated by improvement in signs and symptoms compared to baseline, or by halting of disease progression (no progression of disease signs and symptoms as compared to baseline).

Duration of approval for initiation of therapy: 6 months
Duration of approval for continuation of therapy: 12 months

Reference

Leqselvi (deuruxolitinib) [package insert]. Whippany, NJ: Sun Pharmaceutical Industries, Inc; July 2024. https://www.leqselvi.com/LEQSELVI_PI.pdf

Revision / Date	Implementation Date
Policy Created / June 2025	January 2026