UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2025 P 2380-1
Program	Prior Authorization/Medical Necessity
Medication	Leqselvi™ (deuruxolitinib)* *Leqselvi is excluded from coverage for the majority of our benefits
P&T Approval Date	10/2025
Effective Date	1/1/2026

1. Background:

Leqselvi (deuruxolitinib) is a Janus kinase (JAK) inhibitor indicated for the treatment of adults with severe alopecia areata.

Limitations of Use:
Leqselvi is not recommended for use in combination with other JAK inhibitors, biologic immunomodulators, cyclosporine or other potent immunosuppressants

2. Coverage Criteria[a]:

A. Initial Authorization

1. **Leqselvi** will be approved based on **all** of the following criteria:

   a. Diagnosis of severe alopecia areata

   -AND-

   b. Other causes of hair loss have been ruled out (e.g., androgenetic alopecia, cicatricial alopecias, secondary syphilis, tinea capitis, triangular alopecia, and trichotillomania)

   -AND-

   c. Patient has a current episode of alopecia areata with at least 50% scalp hair loss

   -AND-

   d. History of failure, contraindication, or intolerance to **both** of the following preferred products (document drug, date, and duration of trial):

      (1) Litfulo (ritlecitinib)
      (2) Olumiant (baricitinib)

   -AND-

   e. Patient is not receiving Leqselvi in combination with **either** of the following:

      (1) Systemic targeted immunomodulator [e.g., Litfulo (ritlecitinib), Olumiant (baricitinib)] for treatment of the same indication.

(2) Potent immunosuppressant (e.g., azathioprine or cyclosporine)

-AND-

f. Prescribed by or in consultation with a dermatologist

Authorization will be issued for 12 months.

B. Reauthorization

1. **Leqselvi** will be approved based on **both** of the following criteria:

a. Documentation of positive clinical response to Leqselvi therapy

-AND-

b. Patient is not receiving Leqselvi in combination with **either** of the following:

(1) Systemic targeted immunomodulator [e.g., Litfulo (ritlecitinib), Olumiant (baricitinib)] for treatment of the same indication.
(2) Potent immunosuppressant (e.g., azathioprine or cyclosporine)

Authorization will be issued for 12 months.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

*Leqselvi is excluded from coverage for the majority of our benefits. Tried/failed criteria may be in place. Please refer to plan specifics to determine exclusion status.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4. References:

1. Leqselvi [package insert]. Whippany, NJ: Sun Pharmaceutical Industries, Inc; July 2024.
2. Messenger AG, McKillop J, Farrant P, et al. British Association of Dermatologists' guidelines for the management of alopecia areata 2012. *Br J Dermatol*. 2012;166(5):916-926.
3. King BA, Mesinkovska NA, Craiglow B, et al. Development of the alopecia areata scale for clinical use: results of an academic-industry collaborative effort. J Am Acad Dermatol. 2022;86(2):359-364.
4. Meah N, Wall D, York K, et al. The Alopecia Areata Consensus of Experts (ACE) study: Results of an international expert opinion on treatments for alopecia areata. *J Am Acad Dermatol*. 2020;83(1):123-130.

5. King BA, Senna MM, Ohyama M, et al. Defining Severity in Alopecia Areata: Current Perspectives and a Multidimensional Framework. Dermatol Ther (Heidelb). 2022 Apr;12(4):825-834.

Program	Prior Authorization/Medical Necessity - Leqselvi (deuruxolitinib)
Change Control	
10/2025	New program.