UnitedHealthcare

UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2025 P 1422-3
Program	Prior Authorization/Notification
Medication	Litfulo™ (ritlecitinib)
P&T Approval Date	11/2023, 12/2024, 12/2025
Effective Date	3/1/2026

1. Background:

Litfulo (ritlecitinib) is a kinase inhibitor indicated for the treatment of severe alopecia areata in adults and adolescents 12 years and older.

Limitations of Use:
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. **Litfulo** will be approved based on **both** of the following criteria:

   a. Diagnosis of severe alopecia areata

   -AND-

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

      (1) Biologic immunomodulator or JAK inhibitor [e.g., Adbry (tralokinumab-ldrm), Cibinqo (abrocitinib), Dupixent (dupilumab), Ebglyss (lebrikizumab-lbkz), Leqselvi (deuruxolitinib), Nemluvio (nemolizumab-ilto), Olumiant (baricitinib), Rinvoq (upadacitinib)]
      (2) Potent immunosuppressant (e.g., azathioprine or cyclosporine)

Authorization will be issued for 12 months.

B. Reauthorization

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

   a. Documentation of positive clinical response to Litfulo therapy

   -AND-

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

      (1) Biologic immunomodulator or JAK inhibitor [e.g., Adbry (tralokinumab-ldrm), Cibinqo (abrocitinib), Dupixent (dupilumab), Ebglyss (lebrikizumab-lbkz),

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Leqselvi (deuruxolitinib), Nemluvio (nemolizumab-ilto), Olumiant (baricitinib), Rinvoq (upadacitinib)]

(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.

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, Step Therapy, and/or Medical Necessity may be in place.

4. References:

1. Litfulo [package insert]. New York, NY: Pfizer, Inc.; June 2023.

Program	Prior Authorization/Notification - Litfulo (ritlecitinib)
Change Control	
11/2023	New program.
12/2024	Annual review with no change to coverage criteria.
12/2025	Annual review. Updated combination examples and language with no change to clinical intent.

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