UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2026 P 2396-1
Program	Prior Authorization/Medical Necessity
Medication	Anzupgo® (delgocitinib)
P&T Approval Date	3/2026
Effective Date	5/1/2026

1. Background:

Anzupgo (delgocitinib) is a Janus kinase (JAK) inhibitor indicated for the topical treatment of moderate to severe chronic hand eczema (CHE) in adults who have had an inadequate response to, or for whom topical corticosteroids are not advisable.

Limitations of Use:
Use of Anzupgo in combination with other JAK inhibitors or potent immunosuppressants is not recommended.

2. Coverage Criteria[a]:

A. Initial Authorization

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

   a. Diagnosis of moderate to severe chronic hand eczema

   -AND-

   b. History of failure, contraindication, or intolerance to **both** of the following therapeutic classes of topical therapies:

      (1) One topical corticosteroid of at least medium- to high-potency^ [e.g., Elocon (mometasone furoate), Synalar (fluocinolone acetonide), Lidex (fluocinonide)]
      (2) One topical calcineurin inhibitor [e.g., Elidel (pimecrolimus), Protopic (tacrolimus)]*

   -AND-

   c. Patient is **not** receiving Anzupgo in combination with a biologic medication or JAK inhibitor [e.g., Adbry (tralokinumab-ldrm), Cibinqo (abrocitinib), Dupixent (dupilumab), Ebglyss (lebrikizumab-lbkz), Nemluvio (nemolizumab-ilto), Rinvoq (upadacitinib)]

   -AND-

   d. Patient is **not** receiving Anzupgo in combination with a potent immunosuppressant medication (e.g., azathioprine, cyclosporine)

   -AND-

e. Prescribed by or in consultation with a Dermatologist or Allergist/Immunologist

Authorization will be issued for 12 months.

B. <u>Reauthorization</u>

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

   a. Documentation of positive clinical response to Anzupgo therapy

   -AND-

   b. Patient is **<u>not</u>** receiving Anzupgo in combination with a biologic medication or JAK inhibitor [e.g., Adbry (tralokinumab-ldrm), Cibinqo (abrocitinib), Dupixent (dupilumab), Ebglyss (lebrikizumab-lbkz), Nemluvio (nemolizumab-ilto), Rinvoq (upadacitinib)]

   -AND-

   c. Patient is **<u>not</u>** receiving Anzupgo in combination with a potent immunosuppressant medication (e.g., azathioprine, 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.
^ Tried/Failed alternative(s) are supported by FDA labeling

* Elidel and Protopic/tacrolimus ointment require prior authorization.

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. Anzupgo [package insert]. Madison, NJ: Leo Pharma Inc.; July 2025.

Program	Prior Authorization/ Medical Necessity - Anzupgo (delgocitinib)
Change Control	
3/2026	New program