Zoryve Topicals (roflumilast)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION		
LAST NAME:	**FIRST NAME:**	
PHONE NUMBER:	**DATE OF BIRTH:**	
STREET ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
PATIENT INSURANCE ID NUMBER:		

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION		
LAST NAME:	**FIRST NAME:**	
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**	
NPI NUMBER:	**DEA NUMBER:**	
PHONE NUMBER:	**FAX NUMBER:**	
STREET ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
REQUESTER (if different than prescriber):	**OFFICE CONTACT PERSON:**	

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** **IF RENEWAL:** DATE THERAPY INITIATED: DURATION OF THERAPY (SPECIFIC DATES):			

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ **YES** (if yes, complete below) ☐ **NO**		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ **Plaque Psoriasis** ☐ **Plaque Psoriasis including intertriginous areas** ☐ **Moderate to Severe Seborrheic dermatitis** ☐ **Mild to Moderate Atopic Dermatitis** ☐ Other diagnosis: _____ ICD-10 Code(s):	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Is patient going to be using drug in combination with a clinical trial? ☐ Yes ☐ No

Is the prescriber a dermatologist? □ Yes □ No

Is the request for :
Zoryve 0.3% Cream? □ Yes □ No Zoryve 0.3% FOAM? □ Yes □ No Zoryve 0.15% Cream? □ Yes □ No

<u>For diagnosis of Psoriais, please answer the following:</u>
Is the request for Zoryve 0.3% CREAM? □ Yes □ No

Is the psoriasis affecting 2% - 20% of body surface area? □ Yes □ No (documentation required)

Has the patient had a trial and failure to at least two of the following four topical therapies (topical corticosteroid, topical vitamin D analog, topical calcineurin inhibitor, anthralin) □ Yes □ No (documentation required for drugs, dates, directions and therapy length)

Is the patient receiving therapy with Otezla (apremilast) tablets or any other systemic immunomodulating agent? □ Yes □ No (documentation required if answer is yes)

<u>For diagnosis of Seborrheic dermatitis, please answer the following:</u>
Is the request for Zoryve 0.3% FOAM? □ Yes □ No

Patient has a diagnosis of moderate or severe seborrheic dermatitis? □ Yes □ No Please provide documentation.

Patient has had seborrheic dermatitis for at least 3 months? □ Yes □ No Please provide documentation.

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Patient has tried at least 3 different topical treatments for seborrheic dermatitis, such as topical steroids, sulfur/sulfacetamide products, antifungals, selenium sulfide products, zinc pyrithione products and/or topical calcineurin inhibitor products? □ Yes □ No Please provide documentation with dates of service.

<u>For diagnosis of mild to moderate Atopic dermatitis, please answer the following</u>:
Is the request for Zoryve 0.15% CREAM? □ Yes □ No
Has patient had atopic dermatitis for at least 3 months? □ Yes □ No Please provide documentation.

Has the patient tried at least at least 2 different topical steroids? □ Yes □ No Please provide documentation.

If the patient has not tried at least 2 different topical steroids, has the patient tried at least one topical steroid AND one topical calcineurin inhibitor (tacrolimus or pimecrolimus)? □ Yes □ No Please provide documentation.

<u>Renewal Information:</u>
Is the prescriber a dermatologist? □ Yes □ No

Has the member shown improvement in condition over baseline? □ Yes □ No (documentation required)

Is the patient receiving therapy with Otezla (apremilast) tablets, Sotyktu(deucravacitinib) or any other systemic immunomodulating agent? □ Yes □ No (documentation required if answer is yes)

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

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FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP-4201
P.O. Box 64811

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

St. Paul, MN 55164-0811
Phone: 877-228-7909

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