## **HEALTHY U** MEDICAID

## PRIOR AUTHORIZATION REQUEST FORM

## Zoryve<sup>™</sup>

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please ca	I for assistance: 3	385-425	5-5094			
Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.						
Date: Member Na	Member Name:		ID#:	ID#:		
DOB: Gender:	Gender:		Phy	Physician:		
Office Phone: Office Fax:	Office Fax:		Offi	Office Contact:		
Height/Weight:						
Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.  Product being requested: □ Zoryve (roflumilast)™  Dosing/Frequency: □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □						
If the request is for reauthorization, proceed to reauthorization section.						
Questions		Yes	No	Comments/Notes		
<ol> <li>Is the request made by, or in consultation with, a dermatologist?</li> </ol>						
2. Does the member have a diagnosis of psoriasis?				Please provide documentation		
<ul> <li>3. Does the member take any of the following medications?</li> <li>Biologic DMARDs [e.g., Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab), Cosentyx (secukinumab), Stelara (ustedkinumab), Orencia (abatacept)]; OR</li> <li>Janus Kinase Inhibitors [e.g., Xeljanz (tofacitinib), Oluminat (baricitinib), Rinvoq (upacitinib)]; OR</li> <li>Phosphodiesterase 4 (PDE4) inhibitors [e.g., Otezla (apremilast)]</li> </ul>				Please provide documentation		
4. Is the affected area less than 20% of body surfac	e area?			Please provide documentation		
5. Does documentation show failure or contraindication to topical calcineurin inhibitor, such as pimecrolimus or tacrolimus?				Please provide documentation		
<ul> <li>6. Does documentation show failure or contraindication to ALL of the following?</li> <li>two medium to high potency corticosteroids (e.g., triamcinolone acetonide 0.1%, mometasone furoate 0.1%,</li> </ul>				Please provide documentation		

betamethasone dipropionate 0.05%, desoximetasone 0.05%); AND						
a topical calcineurin inhibitor such as pimecrolimus or						
tacrolimus; AND						
<ul><li>phototherapy</li></ul>						
REAUTHORIZATIO	NI					
REAUTHORIZATION						
Is the requesting for reauthorization of therapy?						
2. Does the member show a continued medical need for the		П	Please provide documentation			
therapy?			Tourse promise documentation			
3. Does the therapy been tolerable and effective?			Please provide documentation			
What medications and/or treatment modalities have been tried in	the pas	st for this	condition? Please document			
name of treatment, reason for failure, treatment dates, etc.	-					
, , ,						
Additional information:						
Physician Signature:						
i nysician signature.						

\*\* Failure to submit clinical documentation to support this request will result in a dismissal of the request.\*\*

Policy: PHARM-HU-147 Origination Date: 01/09/2023 Reviewed/Revised Date: 04/19/2023 Next Review Date: 04/19/2024 Current Effective Date: 05/01/2023

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