

HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM

Zoryve™

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP 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 call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	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
1. Is the request made by, or in consultation with, a dermatologist?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does the member have a diagnosis of psoriasis?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Does the member take any of the following medications? <ul style="list-style-type: none"> • Biologic DMARDs [e.g., Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab), Cosentyx (secukinumab), Stelara (ustedkinumab), Orencia (abatacept)]; OR • Janus Kinase Inhibitors [e.g., Xeljanz (tofacitinib), Oluminat (baricitinib), Rinvoq (upacitinib)]; OR • Phosphodiesterase 4 (PDE4) inhibitors [e.g., Otezla (apremilast)] 	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Is the affected area less than 20% of body surface area?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. Does documentation show failure or contraindication to topical calcineurin inhibitor, such as pimecrolimus or tacrolimus?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
6. Does documentation show failure or contraindication to ALL of the following? <ul style="list-style-type: none"> • two medium to high potency corticosteroids (e.g., triamcinolone acetonide 0.1%, mometasone furoate 0.1%, 	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation

betamethasone dipropionate 0.05%, desoximetasone 0.05%); AND			
<ul style="list-style-type: none"> a topical calcineurin inhibitor such as pimecrolimus or tacrolimus; AND phototherapy 			
REAUTHORIZATION			
1. Is the requesting for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does the member show a continued medical need for the therapy?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Does the therapy been tolerable and effective?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

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

Policy: PHARM-CHIP-147
 Origination Date: 07/01/2024
 Reviewed/Revised Date:
 Next Review Date:
 Current Effective Date: 07/01/2024

Confidentiality Notice

This document and any accompanying document contain confidential information and is intended for the use of the individual or entity named on this transmission sheet. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this information is strictly prohibited and the document should be returned to this office immediately. If you have received this facsimile in error, please notify us by telephone immediately and destroy document received.