PRIOR AUTHORIZATION REQUEST

VTAMA

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is this request for initial therapy or for a continuation of therapy? [] Initial (If checked, go to 7) [] Continuation (If checked, go to 2)		
2	Is the patient currently receiving the requested medication? [If no, skip to question 7.]	Yes	No

If you have any questions, call: 1-888-258-8250

Version 01.2026

PRIOR AUTHORIZATION REQUEST

3	Has the patient been receiving medication samples of the requested medication? [If yes, skip to question 7.]	Yes	No
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 7.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 7.]	Yes	No
6	Has documentation been submitted to confirm that the patient has had a significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
7	What is the diagnosis or indication? [] Plaque psoriasis (If checked, go to 8) [] Atopic dermatitis (If checked, go to 17) [] Other (If checked, no further questions)		
8	Is the patient 18 years of age or older? [If no, no further questions.]	Yes	No
9	Has documentation been provided to confirm the patient has a diagnosis of plaque psoriasis? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
10	Does the patient have documented skin involvement (body surface area [BSA]) of 3% to 20% including face, extremities, trunk, and/or intertriginous areas, excluding scalp, palms, or soles, according to the prescriber? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
11	Has documentation been submitted to confirm that the patient has had treatment failure with TWO medium-, medium-high, high-, and/or super-high-potency prescription topical corticosteroids for at least 28 consecutive days each, unless intolerant or the medication is contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
12	Has the patient tried combination therapy with calcipotriene cream and at least	Yes	No

PRIOR AUTHORIZATION REQUEST

	ONE medium-, medium-high, high-, or super-high-potency prescription topical corticosteroid OR monotherapy of calcitriol ointment for at least 28 consecutive days, unless intolerant or the medication is contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]		
13	Has documentation been submitted to confirm that the patient has had a treatment failure with TWO traditional systemic agents for psoriasis for at least 3 months, unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [Note: Examples include but are not limited to methotrexate, cyclosporine, acitretin (Soriatane, generics).] [If no, no further questions.]	Yes	No
14	Has the patient tried combination therapy with Zoryve for at least 28 consecutive days, unless intolerant or the medication is contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
15	Is the requested medication being prescribed by or in consultation with a dermatologist? [If no, no further questions.]	Yes	No
16	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [Note: Dosing: Apply once daily to affected areas.] [No further questions.]	Yes	No
17	Is the patient greater than or equal to 2 years of age? [If no, no further questions.]	Yes	No
18	Does the patient have a documented diagnosis of atopic dermatitis? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
19	Does the patient have documented skin involvement (body surface area [BSA]) of 5% to 35% including face, extremities, trunk, and/or intertriginous areas, excluding scalp, palms, or soles, according to the prescriber? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
20	Has documentation been submitted to confirm that the patient has had treatment failure with TWO medium-, medium-high, high-, and/or super-high-potency prescription topical corticosteroids for at least 28 consecutive days each, unless intolerant or the medication is contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No

maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

21	Has documentation been submitted to confirm that the patient has had a treatment failure with pimecrolimus or tacrolimus for at least 28 consecutive days, unless intolerant or the medication is contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
22	Has documentation been submitted to confirm that the patient has had a treatment failure with Eucrisa for at least 28 consecutive days, unless intolerant or the is medication contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
23	Is the requested medication being prescribed by or in consultation with an allergist, immunologist, or dermatologist? [If no, no further questions.]	Yes	No
24	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [Note: Dosing: Apply once daily to affected areas.]	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

If you have any questions, call: 1-888-258-8250