PRIOR AUTHORIZATION REQUEST

ZORYVE

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 continuation of therapy? [] Initial (If checked, go to 7) [] Continuation (If checked, go to 2)		
2	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	Yes	No

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	under initial therapy.] [If no, skip to question 7.]		
3	What is the diagnosis or indication? [] Atopic dermatitis (If checked, go to 4) [] Plaque psoriasis (If checked, go to 5) [] Seborrheic dermatitis (If checked, go to 6) [] Other (If checked, no further questions)		
4	Has the patient been taking the requested medication for at least 3 months and has experienced a clinically significant benefit from the medication, as documented by the prescriber? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of a response to the requested medication are marked improvements in erythema, induration/papulation/edema, excoriations, and lichenification; reduced pruritus; decreased requirement for other topical or systemic therapies; reduced body surface area affected with atopic dermatitis; or other responses observed.] [No further questions.]	Yes	No
5	Has the patient been taking the requested medication for at least 3 months and has experienced a clinically significant benefit from the medication, as documented by the prescriber? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of a response to the requested medication are marked improvements assessed by Psoriasis Area and Severity Index, which measures the extent and severity of psoriatic lesions by considering factors like erythema, thickness, scaling, and the affected body surface area (BSA).] [No further questions.]	Yes	No
6	Has the patient been taking the requested medication for at least 3 months and has experienced a clinically significant benefit from the medication, as documented by the prescriber? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of a response to the requested medication are marked improvements assessed by Investigator Global Assessment and a reduction in the Worst Itch-Numeric Rating Scale (WI-NRS).] [No further questions.]	Yes	No
7	What is the diagnosis or indication? [] Atopic dermatitis (If checked, go to 8) [] Plaque psoriasis (If checked, go to 18) [] Seborrheic dermatitis (If checked, go to 28)		

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	[] Other (If checked, no further questions)		
8	Is the patient greater than or equal to 6 years of age? [If no, no further questions.]	Yes	No
9	Does the patient have a documented diagnosis of mild to moderate atopic dermatitis? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
10	Is the requested medication being prescribed by or in consultation with an allergist, immunologist, or dermatologist? [If no, no further questions.]	Yes	No
11	Does the patient have atopic dermatitis involvement estimated to be at least 10% of the body surface area (BSA) according to the prescriber? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 13.]	Yes	No
12	Does the patient have atopic dermatitis affecting the following areas: hands, face, feet, eyes/eyelids, neck, scalp, skin folds, and/or genitalia? [If yes, skip to question 14.]	Yes	No
13	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 1 month within the last 3 months unless intolerant or the medication is contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
14	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
15	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 medication is contraindicated? ACTION REQUIRED: Submit supporting documentation. [Note: Patient should only use the 60 gram tube.] [If no, no further questions.]	Yes	No
16	What medication is being requested? [] Zoryve 0.15% cream (If checked, go to 17)		
	[] Other (If checked, no further questions)		

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17	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [Note: Dosing: 0.15% cream: Apply once daily to affected areas.] [No further questions.]	Yes	No
18	What medication is being requested? [] Zoryve 0.3% cream (If checked, go to 19) [] Zoryve 0.3% topical foam (If checked, go to 20) [] Other (If checked, no further questions)		
19	Is the patient greater than or equal to 6 years of age? [If yes, skip to question 21.] [If no, no further questions.]	Yes	No
20	Is the patient greater than or equal to 12 years of age? [If no, no further questions.]	Yes	No
21	Is the requested medication being prescribed by or in consultation with a dermatologist? [If no, no further questions.]	Yes	No
22	Does the patient have a documented diagnosis of plaque psoriasis? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
23	Has documentation been submitted to confirm that the patient has an estimated 2% to 20% body surface area (BSA) involvement on face, extremities, trunk, and/or intertriginous areas? ACTION REQUIRED: Submit supporting documentation. [Note: Scalp, palms, or soles are excluded from body surface area (BSA) measurement.] [If no, no further questions.]	Yes	No
24	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 1 month within the last 3 months unless intolerant or the medication is contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
25	Has documentation been submitted to confirm that the patient has tried combination therapy with calcipotriene cream AND at least ONE medium-, medium-high, high-, or super-high-potency prescription topical corticosteroid OR monotherapy of calcitriol ointment unless intolerant or the medication is contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No

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26	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 the medication is 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
27	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [Note: Dosing: 0.3% cream/foam: Apply once daily to affected areas.] [No further questions.]	Yes	No
28	What medication is being requested? [] Zoryve 0.3% topical foam (If checked, go to 29) [] Other (If checked, no further questions)		
29	Does the patient have a documented diagnosis of seborrheic dermatitis? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
30	Is the patient greater than or equal to 9 years of age? [If no, no further questions.]	Yes	No
31	Has documentation been submitted to confirm that the patient has an Investigator Global Assessment (IGA) of disease severity of at least 3 at baseline? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
32	Has documentation been submitted to confirm that the patient has had treatment failure with ketoconazole (shampoo or cream) AND ciclopirox for 28 days EACH unless intolerant or the medication is contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
33	Has documentation been submitted to confirm the patient has had treatment failure with TWO medium-, medium-high, high-, and/or super-high-potency prescription topical corticosteroids for AT LEAST 1 month in the last 3 months unless intolerant or the medication is contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
34	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.	Yes	No

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	[If no, no further questions.]		
35	Is the requested medication being prescribed by or in consultation with a dermatologist? [If no, no further questions.]	Yes	No
36	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [Note: Dosing: 0.3% foam: Apply to dry affected area(s) of skin or scalp once daily.]	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.

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