# AvMed

## PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

**Directions**: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

# Topical Phosphodiesterase 4 Inhibitors

**Drug Requested:** select one below

| | |
|---|---|
| ❑ **Eucrisa®** (crisaborole) 2% **ointment** | ❑ **Zoryve®** (roflumilast) **0.15% cream** |

**MEMBER & PRESCRIBER INFORMATION:** Authorization may be delayed if incomplete.

**Member Name:** _____

**Member AvMed #:** _____ **Date of Birth:** _____

**Prescriber Name:** _____

**Prescriber Signature:** _____ **Date:** _____

**Office Contact Name:** _____

**Phone Number:** _____ **Fax Number:** _____

**NPI #:** _____

**DRUG INFORMATION:** Authorization may be delayed if incomplete.

**Drug Name/Form/Strength:** _____

**Dosing Schedule**: _____ **Length of Therapy**: _____

**Diagnosis:** _____ **ICD Code, if applicable:** _____

**Weight (if applicable):** _____ **Date weight obtained:** _____

**Quantity Limit:** 1 tube per 30 days

**CLINICAL CRITERIA:** Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied. Check box below for the Diagnosis that applies.

- ❑ Member must meet **ONE** of the following age requirements:
  - ❑ For Eucrisa® requests: member is ≥ 3 months of age
  - ❑ For Zoryve® requests: member is ≥ 6 years of age
- ❑ Member has a diagnosis of atopic dermatitis for ≥ 3 months

**(Continued on next page)**

- ❑ Member has tried and failed **BOTH** of the following **(verified by chart notes and pharmacy paid claims)**:
  - ❑ At least 14 days of therapy with a topical corticosteroid **(e.g., triamcinolone, mometasone, fluocinolone, fluocinonide, betamethasone)**
  - ❑ At least 30 days of therapy with a topical calcineurin inhibitor **(e.g., tacrolimus ointment, pimecrolimus cream)**

***Not all drugs may be covered under every Plan***

***If a drug is non-formulary on a Plan, documentation of medical necessity will be required.***

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****