

# 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 Zoryve Products

**Drug Requested:** select one drug below

<input type="checkbox"/> Zoryve <sup>®</sup> (roflumilast) 0.15% cream	<input type="checkbox"/> Zoryve <sup>®</sup> (roflumilast) 0.3 % cream
<input type="checkbox"/> Zoryve <sup>®</sup> (roflumilast) topical foam, 0.3%	

**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:** 60 grams (1 tube/can) 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.

**Diagnosis: Atopic Dermatitis**

**Length of Authorization: 12 months**

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- Provider is requesting Zoryve<sup>®</sup> (roflumilast) 0.15% cream (**NOTE: Zoryve<sup>®</sup> 0.3% cream & 0.3% topical foam are not indicated for treatment of atopic dermatitis**)
- Member is  $\geq$  6 years of age
- Member has a diagnosis of atopic dermatitis for  $\geq$  3 months
- 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)

**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.

**Diagnosis: Seborrheic Dermatitis**

**Initial Authorization: 6 months**

- Provider is requesting Zoryve<sup>®</sup> (roflumilast) 0.3% topical foam (**NOTE: Zoryve<sup>®</sup> 0.15% and 0.3% cream not indicated for treatment of seborrheic dermatitis**)
- Member is  $\geq$  9 years of age
- Member has a diagnosis of seborrheic dermatitis
- Member has a history of failure, contraindication, or intolerance to **BOTH** of the following therapies (**chart notes documenting contraindication(s) or intolerance must be attached; trials will be verified using pharmacy claims and/or submitted chart notes**):
  - 30 days of therapy with **ONE** topical corticosteroid (i.e., clobetasol, fluocinonide or mometasone cream/ointment/solution) in the past 180 days
  - 30 days of therapy with **ONE** topical antifungal (ciclopirox shampoo/gel, ketoconazole cream/shampoo, selenium sulfide 2.25% shampoo) in the past 180 days

**Diagnosis: Seborrheic Dermatitis**

**Reauthorization: 12 months.** Check below all that apply. All criteria must be checked 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.

- Member has experienced disease improvement and/or stabilization of seborrheic dermatitis (**chart notes must be submitted**)

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**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.

**Diagnosis: Plaque Psoriasis**

**Initial Authorization: 6 months**

- Provider is requesting Zoryve® (roflumilast) 0.3% cream (**NOTE: Zoryve® 0.15% cream and 0.3% topical foam are not indicated for treatment of plaque psoriasis**)
- Member is  $\geq 6$  years of age
- Member has a diagnosis of plaque psoriasis
- Member has a history of failure, contraindication, or intolerance to **BOTH** of the following therapies (**chart notes documenting contraindication(s) or intolerance must be attached; trials will be verified using pharmacy claims and/or submitted chart notes**):
  - 30 days (14 days for very high potency) of therapy with **ONE** topical corticosteroid in the past 180 days
  - 30 days of therapy with **ONE** other topical agent used for the treatment of psoriasis (e.g., calcipotriene 0.05% ointment or solution, tacrolimus 0.01% or 0.03% ointment, tazarotene 0.1% cream) in the past 180 days

**Diagnosis: Plaque Psoriasis**

**Reauthorization: 12 months.** 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.

- Member has experienced disease improvement and/or stabilization of plaque psoriasis (**chart notes must be submitted**)

*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.\****