SENTARA HEALTH PLANS

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 1-800-750-9692**. 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 Sentara #: _____ **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

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- ❑ 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.****