SENTARA COMMUNITY PLAN
(MEDICAID)

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.**

Immunomodulators Atopic Dermatitis

Drug Requested: (check box be low that applies)

PREFERRED		
❑ **Adbry™** (tralokinumab)	❑ **Dupixent®** (dupilumab) (QL,AG) **(Refer to Dupixent PA form)**	❑ **Ebglyss™** (lebrikizumab-lbkz) **(Refer to Ebglyss PA form)**
❑ **Eucrisa™** (crisaborole)	❑ **Pimecrolimus** (generic Elidel®)	❑ **tacrolimus** (generic Protopic®)
❑ **Vtama®** (tapinarof)		
Non-Preferred		
❑ **Anzupgo®** (delgocitinib)	❑ **Cibinqo™** (abrocitinib) **(Refer to Cibinqo PA form)**	❑ **Nemluvio®** (nemolizumab-ilto) **(Refer to Nemluvio PA form)**
❑ **Opzelura™** (ruxolitinib) (QL, AG) **(Refer to Opzelura PA form)**	❑ **Protopic®** (tacrolimus)	❑ **Zoryve® cream 0.05%**
❑ **Zoryve® cream 0.15%**	❑ **Zoryve® foam 0.3%**	

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 #: _____

(Continued on next page)

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:** _____

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.

Length of Authorization: 1 year

- ❑ Member must have an FDA-approved diagnosis of **Atopic Dermatitis**
  - ❑ **Anzupgo®**: moderate to severe for ages ≥18 years
  - ❑ **Adbry™**: moderate to severe for ages ≥12 years
  - ❑ **Eucrisa™**: mild to moderate for ages equal to or > 3 months
  - ❑ **pimecrolimus**: mild to moderate for ages ≥ 2 years
  - ❑ **Protopic® 0.03%**: moderate to severe for ages ≥ 2 years
  - ❑ **Protopic® 0.1%**: moderate to severe for ages ≥ 16 years
  - ❑ **Zoryve® cream 0.15%:** mild to moderate for ages ≥ 6 years
  - ❑ **Zoryve® cream 0.05%**: mild to moderate for ages 2 to 5 years
  - ❑ **Vtama® cream 0.1%:** for ages ≥ 2 years
- ❑ For **Anzupgo®**:
  - ❑ Member has a diagnosis of moderate to severe chronic hand atopic dermatitis
  - ❑ Member has had inadequate response to or has been unable to use topical steroids
- ❑ For **pimecrolimus** or **tacrolimus**:
  - ❑ Prior documented trial and failure of 8 weeks (or contraindication) to one (1) medium to high potency (e.g., mometasone, triamcinolone) topical corticosteroid
- ❑ For **Adbry®**, **Eucrisa™** or **Vtama®**
  - ❑ Prior documented trial and failure of 30 days (or contraindication) to one (1) medium to high potency (e.g., mometasone, triamcinolone) topical corticosteroid

    OR
  - ❑ Prior documented trial and failure of 30 days (or contraindication) to one (1) topical calcineurin inhibitor (tacrolimus or pimecrolimus)

(Continued on next page)

- ❑ For **Protopic®**:
  - ❑ Failure to topical medium to high potency corticosteroids (e.g., mometasone, triamcinolone)
  - ❑ Failure to **pimecrolimus** and **tacrolimus** (generic)
- ❑ For **Zorvye® cream 0.15%, Zoryve cream® 0.05%**:
  - ❑ Prior documented trial and failure of 8 weeks of each:
    - ❑ One (1) topical corticosteroid of medium to high potency (e.g., mometasone, triamcinolone)
    - ❑ One (1) topical calcineurin inhibitor (tacrolimus or pimecrolimus)
- ❑ For **Vtama®** for plaque psoriasis:
  - ❑ Member is 18 years of age or older
  - ❑ Member has a diagnosis of plaque psoriasis
- ❑ For **Zoryve® foam 0.3%**:
  - ❑ Member is 9 years of age or older and has a diagnosis of seborrheic dermatitis
  - ❑ Prior documented trial and failure of 30 days (or contraindication) to one (1) topical corticosteroid (i.e., clobetasol, fluocinonide or mometasone cream/ointment/solution) in the past 180 days
  - ❑ Prior documented trial and failure of 30 days (or contraindication) to one (1) topical antifungal (ciclopirox shampoo/gel, ketoconazole cream/shampoo, selenium sulfide 2.25% shampoo) in the past 180 days

    OR
  - ❑ Member is 12 years of age or older and has a diagnosis of plaque psoriasis
  - ❑ Member has a history of failure, contraindication, or intolerance to calcipotriene cr/oint/soln

*****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.****

REVISED/UPDATED/REFORMATTED: ~~6/29/2017; 8/29/2017; 8/18/2018; 12/11/2018; 2/27/2019; 6/13/2019; 9/7/2019; 12/22/2020; 12/09/2021; 1/10/2022; 6/29/2022; 7/14/2022; 12/27/2022; 9/14/2023; 12/21/2023, 12/3/2024, 12/12/2024: 9/18/2025; 10/20/2025, 12/13/2025; 6/17/2026;~~
9/18/2026