OPTIMA HEALTH PLAN

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 information provided is not complete, correct, or legible, authorization may be delayed.**

Drug Requested: Topical Psoriasis Medications

❑ **Vtama®** (tapainarof) **1% cream**	❑ **Zoryve™** (roflumilast) **0.3% cream**

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

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

Quantity Limits: 60 grams (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.

Initial Authorization: 6 months

- ❑ Member must meet **ONE** of the following age requirements:
  - ❑ Member is ≥ 18 years of age for Vtama requests
  - ❑ Member is ≥ 12 years of age for Zoryve requests
- ❑ 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 **(requires prior authorization)**] in the past 180 days

Reauthorization: 12 months. All criteria that apply must be checked for approval. To support each line checked, all documentation (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)**

(Continued on next page; signature page is required to process request.)

(Please ensure signature page is attached to form.)

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.****

Member Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***Approved by Pharmacy and Therapeutics Committee**: ~~7/21/2022;~~ **9/15/2022**
REVISED/UPDATED: ~~8/5/2022; 9/9/2022;~~ **10/4/2022**