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; **(Pharmacy) 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 Psoriasis Medications

Drug Requested: (Select drug below)

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

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

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

Weight: _____ **Date:** _____

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 ≥ 6 years of age for Zoryve requests

(Continued on next page)

- ❑ 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. 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.****