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 Zoryve Products

Drug Requested: select one drug below

❑ **Zoryve®** (roflumilast) **0.15% cream**	❑ **Zoryve®** (roflumilast) **0.3 % cream**
❑ **Zoryve®** (roflumilast) **topical 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 #: _____

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® (roflumilast) 0.15% cream **(NOTE: Zoryve® 0.3% cream & 0.3% topical foam are not indicated for treatment of atopic dermatitis)**
- ❑ Member is ≥ 6 years of age
- ❑ Member has a diagnosis of atopic dermatitis for ≥ 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)**

❑ Diagnosis: Seborrheic Dermatitis

Initial Authorization: 6 months

- ❑ Provider is requesting Zoryve® (roflumilast) 0.3% topical foam **(NOTE: Zoryve® 0.15% and 0.3% cream not indicated for treatment of seborrheic dermatitis)**
- ❑ Member is ≥ 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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❑ Diagnosis: Plaque Psoriasis

Initial Authorization: 6 months

- ❑ Provider is requesting **ONE** of the following **(NOTE: Zoryve® 0.15% cream is not indicated for treatment of plaque psoriasis)**:
  - ❑ Zoryve® (roflumilast) 0.3% cream
  - ❑ Zoryve® (roflumilast) 0.3% foam
- ❑ Member must meet **ONE** of the following age requirements for use:
  - ❑ For Zoryve® (roflumilast) 0.3% cream requests: Member is ≥ 6 years of age
  - ❑ For Zoryve® (roflumilast) 0.3% foam requests: Member is ≥ 12 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.****

***Approved by Pharmacy and Therapeutics Committee**: ~~3/21/2024;~~ 7/24/2025
REVISED/UPDATED/REFORMATTED: ~~4/26/2024, 2/20/2025;~~ **8/21/2025**