Prior Authorization Form

CAREFIRST

Zoryve ST with Limit, Post PA

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Zoryve ST with Limit, Post PA.

Drug Name (select from list of drugs shown)

Zoryve (roflumilast) 0.3% Cream Zoryve (roflumilast) 0.3% Foam

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone:

Prescribing Physician

Physician Name: _____

Physician Phone: _____

Physician Fax: _____

Physician Address: _____

City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Is the request for Zoryve (roflumilast) CREAM?	Y N
[If Yes, then go to 2. If No, then go to 6.]	
2. Is the requested drug being prescribed for the topical treatment of plaque psoriasis?	Y N
[If Yes, then go to 3. If No, then no further questions.]	
3. Is the patient 6 years of age or older?	Y N
[If Yes, then go to 4. If No, then no further questions.]	
4. Is the request for continuation of therapy?	Y N

[If Yes, then go to 5. If No, then go to 12.]	
5. Has the patient achieved or maintained a positive clinical response to the requested drug (e.g., clear, or almost clear outcome, patient satisfaction, etc.)?	Y N
[If Yes, then go to 10. If No, then no further questions.]	
6. Is the request for Zoryve (roflumilast) FOAM being prescribed for the topical treatment of seborrheic dermatitis?	Y N
[If Yes, then go to 7. If No, then no further questions.]	
7. Is the patient 9 years of age or older?	Y N
[If Yes, then go to 8. If No, then no further questions.]	
8. Is the request for continuation of therapy?	Y N
[If Yes, then go to 9. If No, then go to 14.]	
9. Has the patient achieved or maintained a positive clinical response to the requested drug (e.g., clear, or almost clear outcome, improvement from baseline, etc.)?	Y N
[If Yes, then go to 10. If No, then no further questions.]	
10. Is the requested drug being prescribed to treat a body surface area that requires more than 60 grams per month?	Y N
[If Yes, then go to 11. If No, then no further questions.]	
11. Does the patient require MORE than the plan allowance of 120 grams per month?	Y N
[No further questions]	
12. Has the patient experienced an inadequate treatment response, intolerance or does the patient have a contraindication to a topical steroid?	Y N
[If Yes, then go to 16. If No, then go to 13.]	
13. Is the requested drug being used on sensitive skin areas (e.g., face, genitals or skin folds)?	Y N
[If Yes, then go to 16. If No, then no further questions.]	
14. Is the patient less than 16 years of age?	Y N
[If Yes, then go to 16. If No, then go to 15.]	
15. Has the patient experienced an inadequate treatment response, intolerance or does the patient have a contraindication to a topical ketoconazole (i.e., 2 percent shampoo, 2 percent cream, 2 percent foam, 2 percent gel) OR a topical ciclopirox (i.e., 0.77 percent gel, 1 percent shampoo) product?	Y N
[If Yes, then go to 16. If No, then no further questions.]	
16. Is the requested drug being prescribed to treat a body surface area that requires more than 60 grams per month?	Y N
[If Yes, then go to 17. If No, then no further questions.]	
17. Does the patient require MORE than the plan allowance of 120 grams per month?	Y N

[No further questions]

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date