PRIOR AUTHORIZATION REQUEST

Zoryve

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

1	Is this request for initial therapy or for a continuation of therapy? [] Initial (If checked, go to 6) [] Continuation (If checked, go to 2)		
2	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 6.]	Yes	No

If you have any questions, call: 1-888-258-8250

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3	What is the diagnosis or indication? [] Atopic dermatitis (If checked, go to 4) [] Plaque Psoriasis (If checked, go to 5) [] Other (If checked, no further questions)		
4	Has the patient been taking the requested medication for at least 3 months and has experienced a clinically significant benefit from the medication, as documented by the prescriber? [Note: Examples of a response to the requested medication are marked improvements in erythema, induration/papulation/edema, excoriations, and lichenification; reduced pruritus; decreased requirement for other topical or systemic therapies; reduced body surface area affected with atopic dermatitis; or other responses observed.] [No further questions.]	Yes	No
5	Has the patient been taking the requested medication for at least 3 months and has experienced a clinically significant benefit from the medication, as documented by the prescriber? [Note: Examples of a response to the requested medication are marked improvements assessed by Psoriasis Area and Severity Index (PASI), which measures the extent and severity of psoriatic lesions by considering factors like erythema, thickness, scaling, and the affected body surface area (BSA).] [No further questions.]	Yes	No
6	What is the diagnosis or indication? [] Atopic dermatitis (If checked, go to 7) [] Plaque Psoriasis (If checked, go to 16) [] Other (If checked, no further questions)		
7	Is the patient greater than or equal to 6 years of age? [If no, no further questions.]	Yes	No
8	Does the patient have a documented diagnosis of mild to moderate atopic dermatitis? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
9	Is the requested medication being prescribed by or in consultation with an allergist, immunologist, or dermatologist? [If no, no further questions.]	Yes	No
10	Does the patient have atopic dermatitis involvement estimated to be at least 10% of the body surface area (BSA) according to the prescriber? ACTION REQUIRED: Submit supporting documentation.	Yes	No

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	[If yes, skip to question 12.]		
11	Does the patient have atopic dermatitis affecting the following areas: hands, face, feet, eyes/eyelids, neck, scalp, skin folds, and/or genitalia? [If yes, skip to question 14.]	Yes	No
12	Has the patient tried at least TWO medium-, medium-high, high-, and/or super-high-potency prescription topical corticosteroids? [If no, no further questions.]	Yes	No
13	Was inadequate efficacy demonstrated with the topical corticosteroid therapy, according to the prescriber? [If no, no further questions.]	Yes	No
14	Has the patient tried a topical calcineurin inhibitor (pimecrolimus or tacrolimus) for at least 28 consecutive days? [If no, no further questions.]	Yes	No
15	Was inadequate efficacy demonstrated with the topical calcineurin inhibitor (pimecrolimus or tacrolimus), according to the prescriber? [No further questions.]	Yes	No
16	Is the patient greater than or equal to 6 years of age? [If no, no further questions.]	Yes	No
17	Is the requested medication being prescribed by or in consultation with a dermatologist? [If no, no further questions.]	Yes	No
18	Does the patient have a documented diagnosis of plaque psoriasis? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
19	Does the patient have skin involvement estimated to be 2% to 20% body surface area (BSA) involvement on face, extremities, trunk, and/or intertriginous areas, excluding scalp, palms, or soles according to the prescriber? [If no, no further questions.]	Yes	No
20	Has the patient tried at least TWO medium-, medium-high, high-, or super-high-potency prescription topical corticosteroids? [If no, no further questions.]	Yes	No
21	Was inadequate efficacy demonstrated with the topical corticosteroid therapy, according to the prescriber? [If no, no further questions.]	Yes	No
22	Has the patient tried combination therapy with calcipotriene cream and at least ONE medium-, medium-high, high-, or super-high-potency prescription topical	Yes	No

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	corticosteroid OR monotherapy of calcitriol ointment? [If no, no further questions.]		
23	Was inadequate efficacy demonstrated with the combination therapy of a topical corticosteroid and calcipotriene cream OR monotherapy of calcitriol ointment, according to the prescriber? [If no, no further questions.]	Yes	No
24	Has the patient tried at least TWO traditional systemic agents for psoriasis for at least 3 months or was intolerant to traditional systemic agents? [Note: Examples include but not limited to methotrexate (MTX), cyclosporine, acitretin (Soriatane, generics), or psoralen plus ultraviolet A light (PUVA).]	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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