US Family Health Plan

Prior Authorization Request Form for

Roflumilast cream (Zoryve)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Clinical documentation may be required for approval.
Prior Authorization does not expire.

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #:		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Is the patient greater than or equal to 6 years of age?	☐ Yes Proceed to question **2**	☐ No **STOP** Coverage not approved
2. Is the medication being prescribed by, or in consultation with a dermatologist?	☐ Yes Proceed to question **3**	☐ No **STOP** Coverage not approved
3. Is the diagnosis plaque psoriasis?	☐ Yes Proceed to question **4**	☐ No **STOP** Coverage not approved
4. Has the patient tried for at least 2 weeks and failed, or has a contraindication to both of the following: • **a topical corticosteroid –** ○ **for patients 18 years of age or older: high potency/class 1 topical corticosteroids (such as, clobetasol propionate 0.05% ointment/cream, fluocinonide 0.05% ointment/cream) OR** ○ **for patients 6 to 17 year of age: any topical corticosteroid AND** • **a topical calcineurin inhibitor (for example, tacrolimus, pimecrolimus)?**	☐ Yes **Sign and date below**	☐ NO Proceed to question **5**

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5. Has the patient had an adverse reaction to both of the following: • **a topical corticosteroid –** ○ **for patients 18 years of age or older: high potency/class 1 topical corticosteroids (such as, clobetasol propionate 0.05% ointment/cream, fluocinonide 0.05% ointment/cream) OR** ○ **for patients 6 to 17 year of age: any topical corticosteroid AND** • **a topical calcineurin inhibitor (for example, tacrolimus, pimecrolimus)?**	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____

[31 July 2024]