USFHP 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

https://www.usfamilyhealth.org/for-providers/pharmacy-information/

Prior Authorization does not expire for plaque psoriasis.

Prior Authorization expires in 1 year for atopic dermatitis. Initial TRICARE/USFHP PA approval required for renewal. Coverage will be approved indefinitely.

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. Has the patient received Zoryve 0.15% or Zoryve 0.05% cream under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for Zoryve 0.15% or Zoryve 0.05% cream.*	☐ Yes Proceed to question **2**	☐ No Proceed to question **3**
2. Has the patient's disease severity improved and stabilized to warrant continues therapy?	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved
3. What is the requested medication?	☐ Zoryve 0.3% cream - Proceed to question **4** ☐ Zoryve 0.15% cream - Proceed to question **7** ☐ Zoryve 0.05% cream - Proceed to question **8**	
4. Is the patient 6 years of age or older?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. What is the indication or diagnosis?	☐ Plaque psoriasis - Proceed to question **6** ☐ Other diagnosis – **STOP - Coverage not approved**	
6. Is the medication being prescribed by, or in consultation with a dermatologist?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**

7. Is the patient 6 years of age or older?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
8. Is the patient 2 to 5 years of age?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. What is the indication or diagnosis?	☐ mild to moderate Atopic Dermatitis - Proceed to question **10** ☐ Other diagnosis – **STOP - Coverage not approved**	
10. Is the requested medication being prescribed by or in consultation with a dermatologist, allergist, or immunologist?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Has the patient tried for at least 2 weeks and failed, or had an adverse reaction to, 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 17 years of age or younger: any topical corticosteroid** • **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