US Family Health Plan
Prior Authorization Request Form for
Roflumilast foam 0.3% (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**

Medical documentation may be required. Failure to provide could result in denial.

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 9 years of age?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the requested medication prescribed by or in consultation with a dermatologist?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Does the patient have a diagnosis of seborrheic dermatitis?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Has the patient tried for at least 2 weeks and failed both of the following: (1) at least one topical corticosteroid; AND (2) at least one topical antifungal?	☐ Yes **Sign and date below**	☐ No Proceed to question **5**
5. Does the patient have a contraindication to both of the following: (1) at least one topical corticosteroid; AND (2) at least one topical antifungal?	☐ Yes **Sign and date below**	☐ No Proceed to question **6**
6. Has the patient had an adverse reaction to both of the following: (1) at least one topical corticosteroid; AND (2) at least one topical antifungal?	☐ Yes **Sign and date below**	☐ No **Coverage not approved**

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

_____ _____
Prescriber Signature Date