USFHP 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

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

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. What is the indication or diagnosis?	☐ seborrheic dermatitis - **Proceed to question 2** ☐ plaque psoriasis - **Proceed to question 6** ☐ Other – **STOP Coverage not approved**	
2. Is the patient greater than or equal to 9 years of age?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. 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 Proceed to question **14**	☐ No Proceed to question **4**
4. 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 Proceed to question **14**	☐ No Proceed to question **5**
5. 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 Proceed to question **14**	☐ No **STOP** **Coverage not approved**
6. Is the patient 12 years of age or older?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. How old is the patient?	☐ 18 years of age or older - Proceed to question **8** ☐ 12-17 years of age - Proceed to question **11**	

8. Has the patient tried for at least 2 weeks and failed both of the following: (1) a high potency/class 1 topical corticosteroids (e.g., clobetasol propionate 0.05% ointment/cream, fluocinonide 0.05% ointment/cream); AND (2) a topical vitamin D analog (for example: calcipotriene foam)?	☐ Yes Proceed to question **14**	☐ No Proceed to question **9**
9. Does the patient have a contraindication to both of the following: (1) a high potency/class 1 topical corticosteroids (for example: clobetasol propionate 0.05% ointment/cream, fluocinonide 0.05% ointment/cream); AND (2) a topical vitamin D analog (for example: calcipotriene foam)?	☐ Yes Proceed to question **14**	☐ No Proceed to question **10**
10. Has the patient had an adverse reaction to both of the following: (1) a high potency/class 1 topical corticosteroids (for example: clobetasol propionate 0.05% ointment/cream, fluocinonide 0.05% ointment/cream); AND (2) a topical vitamin D analog (for example: calcipotriene foam)?	☐ Yes Proceed to question **14**	☐ No **STOP** **Coverage not approved**
11. Has the patient tried for at least 2 weeks and failed both of the following: (1) any topical corticosteroid; AND (2) a topical vitamin D analog (for example: calcipotriene foam)?	☐ Yes Proceed to question **14**	☐ No Proceed to question **12**
12. Does the patient have a contraindication to both of the following: (1) any topical corticosteroid; AND (2) a topical vitamin D analog (for example: calcipotriene foam)?	☐ Yes Proceed to question **14**	☐ No Proceed to question **13**
13. Has the patient had an adverse reaction to both of the following: (1) any topical corticosteroid; AND (2) a topical vitamin D analog (for example: calcipotriene foam)?	☐ Yes Proceed to question **14**	☐ No **STOP** **Coverage not approved**
14. Is the requested medication prescribed by or in consultation with a dermatologist?	☐ 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 _____