PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

4/2/2026

Prior Authorization

Internal Use Only

JOHNS HOPKINS HEALTH PLANS

Zoryve - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**.
Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Zoryve - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Zoryve (roflumilast)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Does the patient meet any of the following criteria: A) Concurrent use with a biologic product to treat the indicated diagnosis, B) Any indications that are not Food and Drug Administration (FDA)-approved, or guideline-supported?	Y N

	[If yes, then no further questions.]		
2.	Is the request for Zoryve cream 0.15 percent?	Y N	
	[If no, then skip to question 12.]		
3.	Does the patient have a documented diagnosis of mild to moderate atopic dermatitis with body surface area (BSA) coverage of 3 to 88 percent? ACTION REQUIRED: If yes, then prescriber MUST submit chart notes that show a diagnosis of mild to moderate atopic dermatitis with BSA coverage of 3 to 88 percent.	Y N	
	[If no, then no further questions.]		
4.	Have chart notes supporting a diagnosis of mild to moderate atopic dermatitis with body surface area (BSA) coverage of 3 to 88 percent been submitted? ACTION REQUIRED: Submit supporting documentation.	Y N	
	[If no, then no further questions.]		
5.	Is this request for a continuation of therapy? [The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.]	Y N	
	[If no, then skip to question 8.]		
6.	Does the patient have documentation showing clinical improvement since starting the requested drug, as evidenced by a score reduction using ONE of the following clinical evaluation tools: A) Investigator's Static Global Assessment (ISGA) decrease from baseline by at least 2 points, B) Eczema Area and Severity Index (EASI) decrease from baseline by at least 75 percent, C) Patient Oriented Eczema Measure (POEM) decrease from baseline by at least 3 points, D) Scoring Atopic Dermatitis (SCORAD) decrease from baseline by at least 50 percent? ACTION REQUIRED: If yes, then prescriber MUST submit chart notes showing a score reduction using one of the above clinical evaluation tools.	Y N	
	[If no, then no further questions.]		
7.	Have chart notes demonstrating the patient's score reduction using of ONE of the following clinical evaluation tools: A) Investigator's Static Global Assessment (ISGA) decrease from baseline by at least 2 points, B) Eczema Area and Severity Index (EASI) decrease from baseline by at least 75 percent, C) Patient Oriented Eczema Measure (POEM) decrease from baseline by at least 3 points, D) Scoring Atopic Dermatitis (SCORAD) decrease from baseline by at least 50 percent been submitted? ACTION REQUIRED: Submit supporting documentation.	Y N	
	[No further questions.]		
8.	Does the patient have documentation showing a baseline assessment has been done using ONE of the following	Y N	

	clinical evaluation tools: A) Investigator's Static Global Assessment (ISGA), B) Eczema Area and Severity Index (EASI), C) Patient-Oriented Eczema Measure (POEM), D) Scoring Atopic Dermatitis (SCORAD) index? ACTION REQUIRED: If yes, then prescriber MUST submit chart notes showing the patient's baseline assessment score.		
	[If no, then no further questions.]		
9.	Have chart notes showing the patient's baseline assessment using ONE of the following clinical evaluation tools: A) Investigator's Static Global Assessment (ISGA), B) Eczema Area and Severity Index (EASI), C) Patient-Oriented Eczema Measure (POEM), D) Scoring Atopic Dermatitis (SCORAD) index been submitted? ACTION REQUIRED: Submit supporting documentation.	Y N	
	[If no, then no further questions.]		
10.	Has the patient had a trial and failure with ALL of the following formulary topical alternatives: A) One or more topical corticosteroids, B) One topical calcineurin inhibitor [e.g., Elidel (pimecrolimus) or Protopic (tacrolimus)], C) Eucrisa (crisaborole)?	Y N	
	[If no, then no further questions.]		
11.	Is the patient 6 years of age or older?	Y N	
	[No further questions.]		
12.	Is the request for Zoryve cream 0.3 percent?	Y N	
	[If no, then skip to question 18.]		
13.	Does the patient have a documented diagnosis of chronic moderate to severe plaque psoriasis with body surface area (BSA) coverage of 2 to 20 percent? ACTION REQUIRED: If yes, then prescriber MUST submit chart notes that show a diagnosis of chronic moderate to severe plaque psoriasis with BSA coverage of 2 to 20 percent.	Y N	
	[If no, then no further questions.]		
14.	Have chart notes supporting a diagnosis of chronic moderate to severe plaque psoriasis with body surface area (BSA) coverage of 2 to 20 percent been submitted? ACTION REQUIRED: Submit supporting documentation.	Y N	
	[If no, then no further questions.]		
15.	Is this request for a continuation of therapy? [The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.]	Y N	
	[If yes, then skip to question 22.]		
16.	Has the patient experienced an insufficient response or does the patient have a contraindication to at least ONE of the following topical pharmacologic therapies: A) corticosteroids (e.g., betamethasone, clobetasol,	Y N	

desonide, etc.), B) Vitamin D analogs (e.g., calcipotriene, etc.), C) Tazarotene, D) Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus, etc.), E) Retinoids?		
[If no, then no further questions.]		
17. Is the patient 6 years of age or older?	Y N	
[No further questions.]		
18. Is the request for Zoryve foam 0.3 percent?	Y N	
[If no, then skip to question 34.]		
19. Does the patient have a documented diagnosis of seborrheic dermatitis? ACTION REQUIRED: If yes, then prescriber MUST submit chart notes that confirm a diagnosis of seborrheic dermatitis.	Y N	
[If no, then skip to question 26.]		
20. Have chart notes supporting a confirmed diagnosis of seborrheic dermatitis been submitted? ACTION REQUIRED: Submit supporting documentation.	Y N	
[If no, then no further questions.]		
21. Is this request for a continuation of therapy? [The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.]	Y N	
[If no, then skip to question 24.]		
22. Has the patient shown documented clinical improvement as supported by ONE of the following: A) Reduction in the signs and symptoms of the indicated condition, B) Prolonged beneficial clinical response, C) Inhibition of structural damage progression, D) Improved clinical functioning? ACTION REQUIRED: If yes, then prescriber MUST submit chart notes that show the patient has experienced clinical improvement as shown by ONE of the following: A) Reduction in the signs and symptoms of the indicated condition, B) Prolonged beneficial clinical response, C) Inhibition of structural damage progression, D) Improved clinical functioning.	Y N	
[If no, then no further questions.]		
23. Have chart notes showing the patient's clinical improvement as demonstrated by ONE of the following: A) Reduction in the signs and symptoms of the indicated condition, B) Prolonged beneficial clinical response, C) Inhibition of structural damage progression, D) Improved clinical functioning been submitted? ACTION REQUIRED: Submit supporting documentation.	Y N	
[No further questions.]		
24. Has the patient experienced an insufficient treatment response or does the patient have a contraindication to at least ONE of the following topical pharmacologic	Y N	

therapies: A) corticosteroids (e.g., betamethasone, clobetasol, desonide, etc.), B) Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus, etc.), C) Topical, shampoo, or systemic antifungals (e.g., ketoconazole, ciclopirox, etc.)?		
[If no, then no further questions.]		
25. Is the patient 9 years of age or older?	Y N	
[No further questions.]		
26. Does the patient have a diagnosis of mild to severe plaque psoriasis of the scalp and body with a body surface area (BSA) coverage of less than or equal to 25 percent (total overall involvement on scalp and non-scalp areas)? ACTION REQUIRED: If yes, then prescriber MUST submit chart notes that confirm a diagnosis of mild to severe plaque psoriasis of the scalp and body with a body surface area (BSA) coverage of less than or equal to 25 percent (total overall involvement on scalp and non-scalp areas?	Y N	
[If no, then no further questions.]		
27. Have chart notes supporting a confirmed diagnosis of mild to severe plaque psoriasis of the scalp and body with a body surface area (BSA) coverage of less than or equal to 25 percent (total overall involvement on scalp and non-scalp areas) been submitted? ACTION REQUIRED: Submit supporting documentation.	Y N	
[If no, then no further questions.]		
28. Is this request for a continuation of therapy? [The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.]	Y N	
[If no, then skip to question 31.]		
29. Has the patient shown documented clinical improvement as supported by ONE of the following: A) Reduction in the signs and symptoms of the indicated condition, B) Prolonged beneficial clinical response, C) Inhibition of structural damage progression, D) Improved clinical functioning? ACTION REQUIRED: If yes, then prescriber MUST submit chart notes that show the patient has experienced clinical improvement as shown by ONE of the following: A) Reduction in the signs and symptoms of the indicated condition, B) Prolonged beneficial clinical response, C) Inhibition of structural damage progression, D) Improved clinical functioning.	Y N	
[If no, then no further questions.]		
30. Have chart notes showing the patient's clinical improvement as demonstrated by ONE of the following: A) Reduction in the signs and symptoms of the indicated condition, B) Prolonged beneficial clinical response, C) Inhibition of structural damage progression, D) Improved	Y N	

clinical functioning been submitted? ACTION REQUIRED: Submit supporting documentation.		
[No further questions.]		
31. Has the patient experienced an insufficient treatment response or does the patient have a contraindication to at least ONE of the following topical pharmacologic therapies: A) Corticosteroids (e.g., betamethasone, clobetasol, desonide, etc.), B) Vitamin D analogs (e.g., calcipotriene, etc.), C) Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus, etc.)?	Y N	
[If no, then no further questions.]		
32. Have chart notes supporting patient experienced an insufficient treatment response or does the patient have a contraindication to at least ONE of the following topical pharmacologic therapies: A) Corticosteroids (e.g., betamethasone, clobetasol, desonide, etc.), B) Vitamin D analogs (e.g., calcipotriene, etc.), C) Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus, etc.) been submitted? ACTION REQUIRED: Submit supporting documentation.	Y N	
[If no, then no further questions.]		
33. Is the patient 12 years of age or older?	Y N	
[No further questions.]		
34. Is the request for Zoryve cream 0.05 percent?	Y N	
[If no, then no further questions.]		
35. Does the patient have a documented diagnosis of mild to moderate atopic dermatitis with body surface area (BSA) coverage of 3 to 82 percent? ACTION REQUIRED: If yes, then prescriber MUST submit chart notes that show a diagnosis of mild to moderate atopic dermatitis with BSA coverage of 3 to 82 percent.	Y N	
[If no, then no further questions.]		
36. Have chart notes supporting a confirmed diagnosis of mild to moderate atopic dermatitis with body surface area (BSA) coverage of 3 to 82 percent been submitted? ACTION REQUIRED: Submit supporting documentation.	Y N	
[If no, then no further questions.]		
37. Is this request for a continuation of therapy? [The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.]	Y N	
[If no, then skip to question 40.]		
38. Does the patient have documentation showing clinical improvement since starting the requested drug, as evidenced by a score reduction using ONE of the following clinical evaluation tools: A) Investigator's Static Global Assessment (ISGA) decrease from baseline by at least 2	Y N	

points, B) Eczema Area and Severity Index (EASI) decrease from baseline by at least 75 percent, C) Patient Oriented Eczema Measure (POEM) decrease from baseline by at least 3 points, D) Scoring Atopic Dermatitis (SCORAD) decrease from baseline by at least 50 percent? ACTION REQUIRED: If yes, then prescriber MUST submit chart notes showing a score reduction using one of the above clinical evaluation tools.		
[If no, then no further questions.]		
39. Have chart notes demonstrating the patient's score reduction using of the following: A) Investigator's Static Global Assessment (ISGA) decrease from baseline by at least 2 points, B) Eczema Area and Severity Index (EASI) decrease from baseline by at least 75 percent, C) Patient Oriented Eczema Measure (POEM) decrease from baseline by at least 3 points, D) Scoring Atopic Dermatitis (SCORAD) decrease from baseline by at least 50 percent been submitted? ACTION REQUIRED: Submit supporting documentation.	Y N	
[No further questions.]		
40. Does the patient have documentation showing a baseline assessment has been done using ONE of the following clinical evaluation tools: A) Investigator's Static Global Assessment (ISGA), B) Eczema Area and Severity Index (EASI), C) Patient-Oriented Eczema Measure (POEM), D) Scoring Atopic Dermatitis (SCORAD) index? ACTION REQUIRED: If yes, then prescriber MUST submit chart notes showing the patient's baseline assessment score.	Y N	
[If no, then no further questions.]		
41. Have chart notes showing the patient's baseline assessment using ONE of the following clinical evaluation tools: A) Investigator's Static Global Assessment (ISGA), B) Eczema Area and Severity Index (EASI), C) Patient-Oriented Eczema Measure (POEM), D) Scoring Atopic Dermatitis (SCORAD) index been submitted? ACTION REQUIRED: Submit supporting documentation.	Y N	
[If no, then no further questions.]		
42. Has the patient had a trial and failure with ALL of the following formulary topical alternatives: A) One or more topical corticosteroids, B) One topical calcineurin inhibitor [e.g., Elidel (pimecrolimus) or Protopic (tacrolimus)], C) Eucrisa (crisaborole)?	Y N	
[If no, then no further questions.]		
43. Have chart notes supporting patient had a trial and failure with ALL of the following formulary topical alternatives: A) One or more topical corticosteroids, B) One topical calcineurin inhibitor [e.g., Elidel (pimecrolimus) or Protopic (tacrolimus)], C) Eucrisa (crisaborole) been submitted? ACTION REQUIRED: Submit supporting documentation.	Y N	

[If no, then no further questions.]	
44. Is the patient between 2 and 5 years of age?	Y N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date