Prior Authorization Request Form for
roflumilast cream **(Zoryve)**

JOHNS HOPKINS
HEALTH PLANS

7231 Parkway Drive, Suite 100
Hanover, MD 21076

Fax completed form and applicable progress notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Prior Authorization does not expire for plaque psoriasis.

Prior Authorization expires in 1 year for atopic dermatitis. Initial TRICARE 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**

Question		
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

[30 October 2025]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: