Prior Authorization Request Form for
roflumilast foam 0.3% **(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.

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

[03 December 2025]

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