

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



JOHNS HOPKINS
HEALTH PLANS

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**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. Is the patient greater than or equal to 6 years of age?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No STOP Coverage not approved
2. Is the medication being prescribed by, or in consultation with a dermatologist?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No STOP Coverage not approved
3. Is the diagnosis plaque psoriasis?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No STOP Coverage not approved
4. Has the patient tried for at least 2 weeks and failed, or has a contraindication to both of the following: <ul style="list-style-type: none"> a topical corticosteroid – <ul style="list-style-type: none"> 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 6 to 17 year of age: any topical corticosteroid AND a topical calcineurin inhibitor (for example, tacrolimus, pimecrolimus)? 	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> NO Proceed to question 5

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<p>5. Has the patient had an adverse reaction to both of the following:</p> <ul style="list-style-type: none">• a topical corticosteroid –<ul style="list-style-type: none">○ 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 6 to 17 year of age: any topical corticosteroid AND• a topical calcineurin inhibitor (for example, tacrolimus, pimecrolimus)?	<p><input type="checkbox"/> Yes Sign and date below</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
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Step 3 I certify the above is true to the best of my knowledge. Please sign and date:

_____ Prescriber Signature

_____ Date

[31 July 2024]

For Internal Use Only	
<input type="checkbox"/> Approved:	Duration of Approval: ____ month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: