TRICARE Prior Authorization Request Form for
roflumilast 0.3% cream **(Zoryve)**

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

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.

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 12 years (s) of age?	☐ Yes Proceed to question **2**	☐ No **STOP** Coverage not approved
2. Is the medication being prescribed by, or in consultation with a dermatologist?	☐ Yes Proceed to question **3**	☐ No **STOP** Coverage not approved
3. Is the diagnosis plaque psoriasis?	☐ Yes Proceed to question **4**	☐ 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: • **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 12 to 17 year of age: any topical corticosteroid AND** • **a topical calcineurin inhibitor (for example, tacrolimus, pimecrolimus)?**	☐ Yes **Sign and date below**	☐ NO Proceed to question **5**

5. Has the patient had an adverse reaction 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 12 to 17 year of age: any topical corticosteroid AND** • **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 _____

[15 February 2023]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#: