Montana Healthcare Programs
Drug Prior Authorization Coverage Criteria

Zoryve™ (roflumilast 0.3%)

Review Criteria

Member must meet all the following criteria:

Initial Criteria:

- Subject to Preferred Drug List requirements
- Member must be 12 years of age or older.
- Member must have a diagnosis of plaque psoriasis.
- Member must have trialed a preferred calcipotriene agent (refer to Preferred Drug List for preferred options).
- Member must have trialed and failed a preferred high potency topical steroid (refer to Preferred Drug List for preferred options).
- Provider attests member does not have moderate to severe liver impairment (Child-Pugh B or C).
- Initial authorization will be approved for 2 months.

Renewal Criteria:

- Provider attests the member has shown improvement in condition over baseline.
- Renewal authorization will be approved for 1 year.

Limitations:

- Maximum quantity – 60gm tube every 28 days