

Montana Healthcare Programs Prior Authorization Request Form for Use of Zoryve® (roflumilast) Cream or Foam

Member Name:	DOB:	Date:
Member ID:	Prescriber Phone:	
Prescriber Name/Specialty if applicable:	Prescriber Fax:	
Dosage Requested:		

Please complete below information for applicable situation, Initiation or Continuation of therapy:

☐ INITIATION OF THERAPY

Zoryve® Cream

1. Member has a diagnosis of plaque psoriasis: ☐ Yes ☐ No
2. Member is 6 years of age or older: ☐ Yes ☐ No
3. Member has had a trial and inadequate response or contraindication to a preferred high potency topical steroid: ☐ Yes ☐ No

Drug name: _____ **Date:** _____

4. Member has had a trial and inadequate response or contraindication to a preferred calcipotriene agent: ☐ Yes ☐ No

Drug name: _____ **Date:** _____

5. Member has trialed and has had an inadequate treatment response, intolerance or contraindication to a preferred drug with the same indication from the Montana Healthcare Programs Preferred Drug List [19 \(mt.gov\)](http://19.mt.gov) (unless preferred product[s] do not have the appropriate indication): ☐ Yes ☐ No

Drug name: _____ **Date:** _____

6. Provider attests to **all the following**:
 - Member does not have moderate to severe liver impairment (Child-Pugh B or C): ☐ Yes ☐ No
 - Baseline assessment has been made to allow for documentation of positive clinical response: ☐ Yes ☐ No

Zoryve® Foam

1. Member has a diagnosis of seborrheic dermatitis: ☐ Yes ☐ No
2. Member is 9 years of age or older: ☐ Yes ☐ No
3. Member has clinical documentation of functional impairment due to seborrheic dermatitis, which may include but is not limited to limitations to activities of daily living (ADLs), such as skin infections or sleep disturbances: ☐ Yes ☐ No

4. Member has had a trial and inadequate response or contraindication to a topical antifungal agent: ☐ Yes ☐ No

Drug name: _____ **Date:** _____

5. Member has had a trial and inadequate response or contraindication to a topical steroid: ☐ Yes ☐ No

Drug name: _____ **Date:** _____

6. Member has had a trial and inadequate response or contraindication to a calcineurin inhibitor: ☐ Yes ☐ No

Drug name: _____ **Date:** _____

7. Member has trialed, and has had an inadequate treatment response, intolerance, or contraindication to a preferred drug with the same indication from the Montana Healthcare Programs Preferred Drug List [19 \(mt.gov\)](https://www.mt.gov) (unless preferred product(s) do not have the appropriate indication): ☐ Yes ☐ No

Drug name: _____ **Date:** _____

8. Provider attests to **all the following**:

- Member does not have moderate to severe liver impairment (Child-Pugh B or C): ☐ Yes ☐ No
- Baseline assessment has been made to allow for documentation of positive clinical response:
☐ Yes ☐ No

LIMITATIONS:

Maximum quantity for initial authorization: 60gm (1 tube or cannister) every 28 days

Initial authorization will be issued for 2 months.

☐ CONTINUATION OF THERAPY

Member has had positive clinical response to therapy (e.g., reduction in the frequency and/or severity of symptoms and exacerbations) over baseline: ☐ Yes ☐ No

LIMITATIONS:

Maximum quantity for renewal authorization: 60gm (1 tube or cannister) every 28 days

Reauthorization will be issued for 12 months.

**Please complete form, including required attachments, and fax to
Drug Prior Authorization Unit at 1-800-294-1350.**