ZORYVE
PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is REQUIRED. Incomplete forms will be returned for additional information. For formulary information please visit *www.myprime.com.* Start saving time today by filling out this form electronically. Visit covermymeds.com to begin using this free service.

What is the priority level of this request?

☐ Standard review
☐ Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

PATIENT AND INSURANCE INFORMATION **Today's Date: ____________**

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis:
☐ Mild to moderate atopic dermatitis
☐ Plaque psoriasis
☐ Seborrheic dermatitis
☐ Other (ICD code and description): ____________

Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

For all requests:

1. Is the patient currently treated with the requested agent? .... ☐ Yes ☐ No
2. Does the patient have any FDA labeled contraindications to the requested agent? .... ☐ Yes ☐ No

   If yes, please specify FDA labeled contraindication(s):____________

   ____
3. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., dermatologist), or has the prescriber consulted with a specialist in the area of the patient's diagnosis? .... ☐ Yes ☐ No
4. Is the patient's age within FDA labeling for the requested indication for the requested agent? .... ☐ Yes ☐ No

   If yes, please provide support for using the requested agent for the patient's age for the requested indication: ________

   ____
5. Is the requested dosage form and strength of Zoryve FDA labeled for the requested indication?.................... ☐ Yes ☐ No
6. Please list all reasons for selecting the requested agent for the indicated diagnosis, strength, dosing schedule, and quantity over alternatives (e.g., compendia support, journal articles, contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). **Please note, documentation may be required:**____________

   ____

   ____

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):

For plaque psoriasis requests:

7. Has the patient tried and had an inadequate response to ONE topical corticosteroid used in the treatment of plaque psoriasis after at least a 2-week duration of therapy OR ONE topical calcineurin inhibitor used in the treatment of plaque psoriasis? ☐ Yes ☐ No
   If yes, please specify agent: ______
   If no, does the patient have an intolerance or hypersensitivity to ONE topical corticosteroid OR ONE topical calcineurin inhibitor used in the treatment of plaque psoriasis? ☐ Yes ☐ No
   If yes, please explain intolerance/hypersensitivity: ______
   If no, does the patient have an FDA labeled contraindication to ALL topical corticosteroids AND ALL topical calcineurin inhibitors used in the treatment of plaque psoriasis? ☐ Yes ☐ No
   If yes, please specify FDA labeled contraindication: ______

For seborrheic dermatitis requests:

7. Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer? ☐ Yes ☐ No
8. Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat an associated condition related to stage four advanced metastatic cancer? **Please note, chart notes are required.** ☐ Yes ☐ No
9. If yes to either of the previous two questions, is the use of the requested agent consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration? ☐ Yes ☐ No
10. Has the patient tried and had an inadequate response to ONE topical antifungal used in the treatment of seborrheic dermatitis? ☐ Yes ☐ No
   If yes, please specify agent: ______
   If no, does the patient have an intolerance or hypersensitivity to ONE topical antifungal used in the treatment of seborrheic dermatitis? ☐ Yes ☐ No
   If yes, please explain intolerance/hypersensitivity: ______
   If no, does the patient have an FDA labeled contraindication to ALL topical antifungals used in the treatment of seborrheic dermatitis? ☐ Yes ☐ No
   If yes, please specify FDA labeled contraindication: ______
11. Has the patient tried and had an inadequate response to ONE topical corticosteroid used in the treatment of seborrheic dermatitis? ☐ Yes ☐ No
   If yes, please specify agent: ______
   If no, has the patient tried and had an inadequate response to ONE topical calcineurin inhibitor (e.g., pimecrolimus, tacrolimus) used in the treatment of seborrheic dermatitis? ☐ Yes ☐ No
   If yes, please specify agent: ______
   If no, does the patient have an intolerance or hypersensitivity to ONE topical calcineurin inhibitor (e.g., pimecrolimus, tacrolimus) used in the treatment of seborrheic dermatitis? ☐ Yes ☐ No
   If yes, please explain intolerance/hypersensitivity: ______
   If no, does the patient have an FDA labeled contraindication to ALL topical corticosteroids AND topical calcineurin inhibitors used in the treatment of seborrheic dermatitis? ☐ Yes ☐ No
   If yes, please specify FDA labeled contraindication: ______

12. Does the patient have seborrheic dermatitis of the scalp? ☐ Yes ☐ No
   If yes, does the patient have an FDA labeled contraindication to ALL topical corticosteroids used in the treatment of seborrheic dermatitis? ☐ Yes ☐ No
   If yes, please specify FDA labeled contraindication: ______

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):

For mild to moderate atopic dermatitis requests:

- **For the following questions please submit medical records:**

13. Has the patient tried and had an inadequate response to ONE at least medium-potency topical corticosteroid used in the treatment of AD after at least a 4-week duration of therapy? ☐ Yes ☐ No
    - If no, was ONE at least medium-potency topical corticosteroid used in the treatment of AD discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No
      - If no, does the patient have an intolerance or hypersensitivity to ONE at least medium-potency topical corticosteroid used in the treatment of AD?. ☐ Yes ☐ No
        - If no, does the patient have an FDA labeled contraindication to ALL medium-, high-, and super-potency topical corticosteroids used in the treatment of AD? ☐ Yes ☐ No
          - If no, is ONE at least medium-potency topical corticosteroid used in the treatment of AD expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? ☐ Yes ☐ No
            - If no, is ONE at least medium-potency topical corticosteroid used in the treatment of AD not in the best interest of the patient based on medical necessity? ☐ Yes ☐ No
              - If no, has the patient tried and had an inadequate response to ONE topical calcineurin inhibitor (e.g., Elidel/pimecrolimus, Protopic/tacrolimus) used in the treatment of AD after at least a 6-week duration of therapy? ☐ Yes ☐ No
14. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as ONE at least medium-potency topical corticosteroid used in the treatment of AD and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No
    - If no, was ONE topical calcineurin inhibitor used in the treatment of AD discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No
      - If no, does the patient have an intolerance or hypersensitivity to ONE topical calcineurin inhibitor used in the treatment of AD? ☐ Yes ☐ No
        - If no, is ONE topical calcineurin inhibitor used in the treatment of AD expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? ☐ Yes ☐ No
          - If no, does the patient have an FDA labeled contraindication to ALL topical calcineurin inhibitors used in the treatment of AD? ☐ Yes ☐ No
            - If no, is ONE topical calcineurin inhibitor used in the treatment of AD not in the best interest of the patient based on medical necessity? ☐ Yes ☐ No
              - If no, has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as ONE topical calcineurin inhibitor used in the treatment of AD and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No
15. Is the patient currently treated with topical emollients and practicing good skin care? ☐ Yes ☐ No
    - If yes, will the patient continue the use of topical emollients and good skin care practices in combination with the requested agent? ☐ Yes ☐ No

For renewal requests:

16. Has the patient had clinical benefit with the requested agent? ☐ Yes ☐ No

For mild to moderate atopic dermatitis requests:

17. Will the patient continue standard maintenance therapies (e.g., topical emollients, good skin care practices) in combination with the requested agent? ☐ Yes ☐ No

Please fax or mail this form to:
Prime Therapeutics LLC
Clinical Review Department
2900 Ames Crossing Road Suite 200
Eagan, MN 55121

TOLL FREE

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