STANDARD COMMERCIAL DRUG FORMULARY
PRIOR AUTHORIZATION GUIDELINES

ROFLUMILAST

Generic	Brand	HICL	GCN	Medi-Span	Exception/Other
ROFLUMILAST	ZORYVE	37123		GPI-10 (9025004500)	ROUTE = TOPICAL

GUIDELINES FOR USE

INITIAL CRITERIA (NOTE: FOR RENEWAL CRITERIA SEE BELOW)

1. Does the patient have a diagnosis of plaque psoriasis and meet **ALL** of the following criteria?
   - The patient is 12 years of age or older
   - Therapy is prescribed by or in consultation with a dermatologist
   - The patient has psoriasis covering 2% to 20% of body surface area (BSA) (excluding scalp, palms, and soles)
   - The patient is NOT concurrently using other systemic immunomodulating agents (e.g., Stelara, Otezla), topical corticosteroids (e.g., betamethasone dipropionate, clobetasol propionate), or topical non-steroidals (e.g., calcitriol, tazarotene)

   If yes, continue to #2.
   If no, do no approve.
   DENIAL TEXT: See the initial denial text at the end of the guideline.

2. Has the patient had a trial of or contraindication to **TWO** of the following (from different categories)?
   - High or super-high potency topical corticosteroid (e.g., triamcinolone acetonide, fluocinonide, clobetasol propionate, halobetasol propionate)
   - Topical vitamin D analog (e.g., calcipotriene cream, calcitriol ointment)
   - Topical calcineurin inhibitor (e.g., tacrolimus, pimecrolimus)
   - Topical retinoid (e.g., tazarotene cream/gel)
   - Anthralin

   If yes, **approve for 2 months by GPID or GPI-10.**
   If no, do not approve.
   INITIAL DENIAL TEXT: *Some terms are already pre-defined in parenthesis. Please use these definitions if the particular text you need to use does not already have definition(s) in it.

   Our guideline named **ROFLUMILAST (Zoryve)** requires the following rule(s) be met for approval:
   A. You have plaque psoriasis (a type of skin condition)
   B. You are 12 years of age or older
   C. Therapy is prescribed by or in consultation with a dermatologist (a type of skin doctor)
   (Initial denial text continued on next page)

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ROFLUMILAST

INITIAL CRITERIA (CONTINUED)

D. You have psoriasis covering 2% to 20% of body surface area (BSA) (excluding scalp, palms, and soles)
E. You are NOT concurrently (at the same time) using other systemic immunomodulating agents (such as Stelara, Otezla), topical corticosteroids (such as betamethasone dipropionate, clobetasol propionate), or topical non-steroidals (such as calcitriol, tazarotene)
F. You had a trial of or contraindication (harmful for) to TWO of the following (from different categories):
    1. High or super-high potency topical corticosteroid (such as triamcinolone acetonide, fluocinonide, clobetasol propionate, halobetasol propionate)
    2. Topical vitamin D analog (such as calcipotriene cream, calcitriol ointment)
    3. Topical calcineurin inhibitor (such as tacrolimus, pimecrolimus)
    4. Topical retinoid (such as tazarotene cream/gel)
    5. Anthralin

Your doctor told us [INSERT PT SPECIFIC INFO PROVIDED]. We do not have information showing you [INSERT UNMET CRITERIA]. This is why your request is denied. Please work with your doctor to use a different medication or get us more information if it will allow us to approve this request.

RENEWAL CRITERIA

1. Does the patient have a diagnosis of plaque psoriasis and meet **ALL** of the following criteria?
    - The patient has achieved or maintained clear or minimal disease
    - The patient is NOT concurrently using other systemic immunomodulating agents (e.g., Stelara, Otezla), topical corticosteroids (e.g., betamethasone dipropionate, clobetasol propionate), or topical non-steroidals (e.g., calcitriol, tazarotene)

    If yes, **approve for 12 months by GPID or GPI-10.**
    If no, do not approve.
    RENEWAL DENIAL TEXT: *Some terms are already pre-defined in parenthesis. Please use these definitions if the particular text you need to use does not already have definition(s) in it.

    Our guideline named **ROFLUMILAST (Zoryve)** requires the following rule(s) be met for renewal:
    A. You have plaque psoriasis (a type of skin condition)
    B. You have achieved or maintained clear or minimal disease
    C. You are NOT concurrently (at the same time) using other systemic immunomodulating agents (such as Stelara, Otezla), topical corticosteroids (such as betamethasone dipropionate, clobetasol propionate), or topical non-steroidals (such as calcitriol, tazarotene)
    (Renewal denial text continued on next page)

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ROFLUMILAST

RENEWAL CRITERIA (CONTINUED)

Your doctor told us [INSERT PT SPECIFIC INFO PROVIDED]. We do not have information showing you [INSERT UNMET CRITERIA]. This is why your request is denied. Please work with your doctor to use a different medication or get us more information if it will allow us to approve this request.

RATIONALE

For further information, please refer to the Prescribing Information and/or Drug Monograph for Zoryve.

REFERENCES

- Zoryve [Prescribing Information]. Westlake Village, CA: Arcutis Biotherapeutics, Inc.; July 2022.

Library	Commercial	NSA
Yes	Yes	No

Part D Effective: N/A
Commercial Effective: 08/29/22
Created: 08/22
Client Approval: 08/22
P&T Approval: 07/22