

**Zoryve 0.3% Foam (Non-PDL)**

Phone: 215-991-4300

Fax back to: 866-240-3712

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.**

Patient Name:		Prescriber Name:	
HPP HPP Member Number:		Fax:	Phone:
Date of Birth:		Office Contact:	
Patient Primary Phone:		NPI:	PA PROMISe ID:
Address:		Address:	
City, State ZIP:		City, State ZIP:	
Line of Business: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP		Specialty Pharmacy (if applicable):	
Drug Name:		Strength:	
Quantity:		Refills:	
Directions:			
Diagnosis Code:		Diagnosis:	
<i>HPP's maximum approval time is 12 months but may be less depending on the drug.</i>			

**Please attach any pertinent medical history including labs and information for this member that may support approval.**

***Please answer the following questions and sign.***

Q1. Is the request for reauthorization of Zoryve 0.3% foam? If YES, go to 7.

Yes

No

Q2. Does the patient have a diagnosis of seborrheic dermatitis?

Yes

No

Q3. Is the patient age appropriate according to the FDA approved package labeling?

Yes

No

Q4. Is the medication prescribed by or in consultation with a dermatologist?

Yes

No

Q5. Does the patient have severe liver impairment (Child Pugh class B or C)?

Yes

No

Q6. Does the patient have a history of therapeutic failure, intolerance to, or contraindication to at least a 4-week trial of two of the following: one topical corticosteroid, one topical antifungal, or

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one topical calcineurin inhibitor (such as betamethasone, hydrocortisone, ketoconazole, ciclopirox, tacrolimus ointment, Elidel cream)?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q7. Does the patient continue to need Zoryve 0.3% foam and meet the criteria identified for initial approval?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q8. Does the patient tolerate the medication without significant or serious side effects (must attach documentation)?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. Has the patient had an improvement in symptoms from baseline (must attach documentation)?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q10. Additional Information	

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

v2024