ANTIPSORIATICS, TOPICAL PRIOR AUTHORIZATION FORM *(form effective 1/5/2026)*

FAX this completed form to (844) 205-3386
OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720
OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/

Prior authorization guidelines for **Antipsoriatics, Topical** and **Quantity Limits/Daily Dose Limits** are available on the PA Health & Wellness website at https://www.pahealthwellness.com/providers/pharmacy.html.

☐New request ☐Renewal request	Total pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Member name:		City/state/zip:	
Member ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Strength:	
Dose/directions:	Quantity:	Refills:
Diagnosis *(submit documentation)*:	Dx code (*required*):	

Complete all sections that apply to the member and this request.
Check all that apply and submit documentation for each item.

INITIAL requests

1. For a TOPICAL AhR AGONIST (eg, Vtama):

☐**For the treatment of PSORIASIS,** tried and failed or cannot try (due to a contraindication or an intolerance) to BOTH of the following:
- ☐A 4-week trial of a topical corticosteroid
- ☐An 8-week trial of a non-steroidal topical drug (eg, topical calcineurin inhibitor, topical retinoid, topical vitamin D analog)

☐**For the treatment of ALL OTHER diagnoses,** list other treatments tried (including start/stop dates, dose, outcomes, etc.):

_____

2. For a TOPICAL PDE4 INHIBITOR (eg, Zoryve):

☐**For the treatment of PSORIASIS:**
- ☐Tried and failed or cannot try (due to a contraindication or an intolerance) topical calcipotriene

☐**For the treatment of SEBORRHEIC DERMATITIS,** tried and failed or cannot try (due to a contraindication or an intolerance) at least ONE of the following:
- ☐A 4-week trial of a topical antifungal

☐ A 4-week trial of a topical corticosteroid

☐ A 4-week trial of a topical calcineurin inhibitor (eg, pimecrolimus, tacrolimus)

☐ **For the treatment of ALL OTHER diagnoses,** list other treatments tried (including start/stop dates, dose, outcomes, etc.):

_____

3. For <u>all other NON-PREFERRED Antipsoriatics, Topical (eg, vitamin D derivatives)</u>:

☐ Tried and failed or has a contraindication or an intolerance to the preferred Antipsoriatics, Topical *(Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*

RENEWAL requests

1. For a <u>TOPICAL PDE4 INHIBITOR</u> (eg, Zoryve):

☐ Has documented evidence of a positive clinical response

2. For a <u>TOPICAL AhR AGONIST</u> (eg, Vtama):

☐ Has documented evidence of a positive clinical response

3. For <u>all other NON-PREFERRED Antipsoriatics, Topical (eg, vitamin D derivatives)</u>:

☐ Has documented evidence of a positive clinical response

☐ Tried and failed or has a contraindication or an intolerance to the preferred Antipsoriatics, Topical *(Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*

PLEASE <u>FAX</u> COMPLETED FORM WITH <u>REQUIRED CLINICAL DOCUMENTATION</u> TO 844-205-3386

Prescriber Signature:	**Date**:

Pharmacy Department will respond via fax or phone within 24 hours.

Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)