Policy Name:	Zoryve (roflumilast)	Policy#:	3155P

Purpose of the Policy

StatementoftthePolicy

Health Alliance Medical Plans will approve the use of topical Zoryve (roflumilast) under the pharmacy benefit, when the following criteria have been met:

Criteria

1. Coverage Criteria for Psoriasis (0.3% cream)

1.1 Diagnosis of plaque psoriasis with body surface area (BSA) less than or equal to 20%

1.2 Age 6 years or older

1.3 Prescribed by or in consultation with a dermatologist (skin doctor) or rheumatologist (musculoskeletal doctor)

1.4 Documented failure, intolerance, or contraindication to a high potency topical steroid

1.5 Documented failure, intolerance, or contraindication to calcipotriene topical OR tazarotene topical

2. Coverage Criteria for Psoriasis (foam)

2.1 Diagnosis of plaque psoriasis of the scalp and body

2.2 Age 12 years or older

2.3 Prescribed by or in consultation with a dermatologist or rheumatologist

2.4 Documented failure, intolerance, or contraindication to a high potency topical steroid

2.5 Documented failure, intolerance, or contraindication to calcipotriene topical (such as tacrolimus or pimecrolimus) or tazarotene topical

3. Coverage Criteria for Atopic Dermatitis (0.15% cream)

3.1 Diagnosis of mild to moderate atopic dermatitis

3.2 Age 6 years or older

3.3 Prescribed by or in consultation with a dermatologist (skin doctor)

3.4 Documented failure, intolerance, or contraindication to a topical corticosteroid

3.5 Documented failure, intolerance, or contraindication to a topical calcineurin inhibitor (such as tacrolimus or pimecrolimus

4. Coverage Criteria for Seborrheic Dermatitis (foam)

4.1 Documented diagnosis of seborrheic dermatitis present on face and/or scalp

4.2 Age 9 years or older

4.3 Prescribed by or in consultation with a dermatologist (skin doctor)

4.4 Documented failure, intolerance, or contraindication to a generic topical antifungal (such as ketoconazole)

4.5 Documented failure, intolerance, or contraindication to a generic topical anti-inflammatory (such as topical corticosteroids, topical calcineurin inhibitors)

5. Managed Dose Limit

5.1 60 grams (1 tube) per 30 days

6. Approval Period

6.1 Initial authorization: 12 months

6.2 Subsequent authorizations: 12 months with documented beneficial clinical response to therapy

References

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