

## Phosphodiesterase-4 (PDE-4) Inhibitors (topical) Prior Authorization

<b>Drug(s) Applied:</b>	<b>Eucria 2%</b> (crisaborole) ointment <b>Zoryve 0.05%</b> (roflumilast) cream <b>Zoryve 0.15%</b> (roflumilast) cream <b>Zoryve 0.3%</b> (roflumilast) cream/foam
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### Criteria:

Drug(s) Applied will be approved when the requested medication is being used for an FDA approved indication and all of the following criteria are met:

#### I. Initial Therapy Criteria

##### A. Atopic Dermatitis as indicated by chart notes within the past 180 days

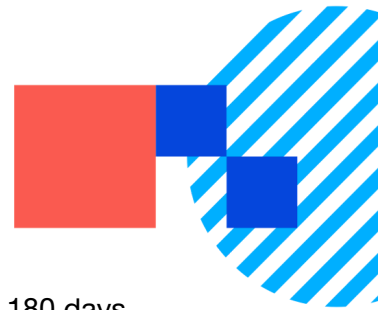
1. Requested agent is Eucria 2% or Zoryve 0.15% or Zoryve 0.05% **and**
2. If for Zoryve 0.05%, member is between 2 and 5 years old **and**
3. Patient has tried and had an inadequate response to a mid-potency topical corticosteroid or stronger for a minimum of 4 weeks **and**
4. Patient has tried and had an inadequate response to a topical calcineurin inhibitor (e.g., pimecrolimus, tacrolimus) for a minimum of 6 weeks **or**
5. Patient has an intolerance to both therapies **and**
6. Prescriber is a specialist or has consulted with a specialist in the area of the patient's diagnosis (e.g., dermatology)

**Approval Duration:** 12 months

##### B. Plaque Psoriasis as indicated by chart notes within the past 180 days

1. Requested agent is Zoryve 0.3% **and**
2. Patient has tried and had an inadequate response to a topical corticosteroid for a minimum of 4 weeks or has an intolerance **and**
3. Patient has tried and had an inadequate response to another topical psoriasis agent with a different mechanism of action (e.g., vitamin D analogs, tazarotene) for a minimum of 4 weeks or has an intolerance **and**
4. Prescriber is a specialist or has consulted with a specialist in the area of the patient's diagnosis (e.g., dermatology)

**Approval Duration:** 12 months



**C. Seborrheic Dermatitis** as indicated by chart notes within the past 180 days

1. Requested agent is Zoryve 0.3% foam **and**
2. Patient has tried and had an inadequate response to at least one topical antifungal (i.e., ciclopirox, ketoconazole) or sulfacetamide sodium-sulfur for a minimum of 4 weeks or patient has an intolerance to all therapies

**Approval duration:** 12 months

II. Continued Therapy Criteria

**A. Atopic Dermatitis** as indicated by chart notes within the past 12 months

1. Patient meets the initial therapy criteria above **and**
2. Patient has had clinical benefit with the requested agent

**Approval Duration:** 12 months

**B. Plaque Psoriasis** as indicated by chart notes within the past 12 months

1. Patient meets the initial therapy criteria above **and**
2. Patient has had clinical benefit with the requested agent

**Approval Duration:** 12 months

**C. Seborrheic Dermatitis** as indicated by chart notes within the past 12 months

1. Patient meets the initial therapy criteria above **and**
2. Patient has had clinical benefit with the requested agent

**Approval Duration:** 12 months

**Policy Owned by:** Curative PBM team