curative

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

Drug(s) Applied:	**Eucrisa 2%** (crisaborole) ointment **Zoryve 0.15%** (roflumilast) cream **Zoryve 0.3%** (roflumilast) cream/foam

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 Eucrisa 2% or Zoryve 0.15% **and**
2. Patient has tried and had an inadequate response to a mid-potency topical corticosteroid or stronger for a minimum of 4 weeks **and**
3. Patient has tried and had an inadequate response to a topical calcineurin inhibitor (e.g., pimecrolimus, tacrolimus) for a minimum of 6 weeks **or**
4. Patient has an intolerance to both therapies **and**
5. 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