STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES TELEPHONE:
TELEPHONE: 1-866-409-8386 FAX: 1-866-759-4110

Antipsoriatic Topical Agents - Vitamin D Analogs
Prior Authorization (PA) Request Form
CT Medical Assistance Program
To Be Completed By Prescriber

Prescriber Information	Patient Information
Prescriber's NPI:	Patient's Medicaid ID Number:
Prescriber Name:	Patient Name:
Prescriber Subspecialty:	Patient Date of Birth:
Phone ( )	Patient Current Weight:
Fax ( )	Patient Primary ICD Diagnosis Code:
Prescription Information	
Drug, Strength, and Dosage Form Requested:	Frequency of Dosing:
□ New therapy □ Continuation	Quantity Requested:

Preferred Agents:	Non-Preferred Agents:
CALCIPOTRIENE CREAM	CALCIPOTRIENE FOAM
CALCIPOTRIENE OINTMENT	CALCIPOTRIENE/BETAMETHASONE SUSPENSION
CALCIPOTRIENE SOLUTION	CALCITRIOL OINTMENT (generic Vectical)
CALCIPOTRIENE/BETAMETHASONE OINTMENT	ENSTILAR FOAM
VECTICAL OINTMENT (BRAND PREFERRED)	SORILUX FOAM
	TACLONEX OINTMENT
	TACLONEX SCALP SUSPENSION
	ZORYVE 0.3% CREAM (NOT 0.05% OR 0.15%)
	ZORYVE 0.3% FOAM

Clinical Information

(attach supporting documentation, **required**)

Note: Using samples to initiate therapy does not meet authorization requirements

1. Prescribed by or in consultation with a dermatologist or other specialist familiar with the treated disease state (or as appropriate for diagnosis)? • Please Specify:_____	□ Yes □ No
2. For all Non-Preferred Agents (with the exception of Zoryve): Patient has trialed and failed ONE preferred Topical Antipsoriatic Agent (Vitamin D Analog) for a minimum of 30 days within the	□ Yes □ No

previous 6 months OR patient has a Documented Adverse Reaction/Adverse Event or Contraindication to ALL preferred agents: • Preferred agent trialed: _____ • Trial Dates: _____ • Reason for Failure: _____ • If Adverse Reaction, Adverse Event, or Contraindication, please specify details: _____ _____ • Clinical justification documentation why a preferred formulation is not appropriate is required or documentation of the absence of appropriate formulation of preferred agent/product: _____ _____	
3. For Zoryve Requests: Patient experienced trial and failure of ONE preferred product within required classes based on the one of the following Documented Diagnosis: • **<u>Plaque Psoriasis:</u> Trial and failure of ONE preferred product within the Topical Antipsoriatic Agent (Vitamin D Analog) OR Topical Corticosteroids class within previous 6 months:** o Preferred Topical Agent trialed: _____ o Trial Dates: _____ o Reason for Failure: _____ **OR** o Patient has documented contraindication to ALL preferred Topical Vitamin D Analogs and Topical Corticosteroid products (provide documentation): ▪ Clinical rationale must be provided with medical reasoning: _____ _____ • **<u>Seborrheic Dermatitis:</u> Trial and failure of ONE preferred product within the Topical Antifungal OR Topical Corticosteroids class within previous 6 months:** o Preferred Topical Agent trialed: _____ o Trial Dates: _____	□ Yes □ No

○ Reason for Failure: _____ **OR** ○ Patient has documented contraindication to ALL Topical Antifungal AND Topical Corticosteroid products (provide documentation): ▪ Clinical rationale must be provided with medical reasoning: _____ _____	

For Initial Approval:
Medication Requested and Documented diagnosis of ONE of the following:

(attach supporting documentation, **required**)

Calcipotriene Foam (4+ years of age): • Patient has a documented diagnosis of Plaque Psoriasis of the Scalp and/or Body **AND** • Failure to achieve the desire therapeutic outcome following trial and failure of a preferred Topical Antipsoriatic Agent (Vitamin D Analog) (as outlined above in question 2 of the Clinical Information section)	□ Yes □ No
Calcipotriene/Betamethasone Scalp Suspension (12+ years of age): • Patient has a documented diagnosis of Plaque Psoriasis of the Scalp and/or Body **AND** • Failure to achieve the desire therapeutic outcome following trial and failure of a preferred Topical Antipsoriatic Agent (Vitamin D Analog) (as outlined above in question 2 of the Clinical Information section)	□ Yes □ No
Calcitriol Ointment (2+ years of age): • Patient has a documented diagnosis of Mild to Moderate Plaque Psoriasis (PsO) **AND** • Failure to achieve the desire therapeutic outcome following trial and failure of a preferred Topical Antipsoriatic Agent (Vitamin D Analog) (as outlined above in question 2 of the Clinical Information section) **AND** • Documented medical reason preferred BRAND Vectical cannot be used:_____ _____	□ Yes □ No
Enstilar Foam (calcipotriene/betamethasone dipropionate) (+12 years of age): • Patient has a documented diagnosis of Plaque Psoriasis (PsO) **AND**	□ Yes □ No

• Failure to achieve the desire therapeutic outcome following trial and failure of a preferred Topical Antipsoriatic Agent (Vitamin D Analog) (as outlined above in question 2 of the Clinical Information section)	
Sorilux Foam (calcipotriene) (4+ years of age): • Patient has a documented diagnosis of Plaque Psoriasis of the Scalp and/or Body **AND** • Failure to achieve the desired therapeutic outcome following trial and failure of a preferred Topical Antipsoriatic Agent (Vitamin D Analog) (as outlined above in question 2 of the Clinical Information section) **AND**	□ Yes □ No
Taclonex Suspension (calcipotriene) (12+ years of age): • Patient has a documented diagnosis of Plaque Psoriasis of the Scalp and/or Body **AND** • Failure to achieve the desired therapeutic outcome following trial and failure of a preferred Topical Antipsoriatic Agent (Vitamin D Analog) (as outlined above in question 2 of the Clinical Information section)	□ Yes □ No
Zoryve 0.3% Cream (roflumilast) (6+ years of age): • Patient has a documented diagnosis of Plaque Psoriasis, including Intertriginous Areas **AND** • Prescriber attests patient does NOT have a diagnosis of moderate to severe liver impairment (Child-Pugh B or C) **AND** • Failure to achieve the desired therapeutic outcome following trial and failure of a preferred Topical Antipsoriatic Agent (Vitamin D Analog) or Topical Corticosteroids class within the previous 6 months (as outlined above in question 3 of the Clinical Information section)	□ Yes □ No

Zoryve 0.3% Foam (roflumilast):
• Prescriber attests patient does NOT have a diagnosis of moderate to severe liver impairment (Child-Pugh B or C) **AND**
• Patient has a documented diagnosis of ONE of the following:
  o Plaque Psoriasis of the Scalp and/or Body (12+ years of age)
  ▪ Failure to achieve the desired therapeutic outcome following trial and failure of a preferred Topical Antipsoriatic Agent (Vitamin D Analog) or Topical Corticosteroids class within the previous 6 months (as outlined above in question 3 of the Clinical Information section)
	□ Yes □ No

○ Seborrheic Dermatitis (9+ years of age) ▪ Failure to achieve the desired therapeutic outcome following trial and failure of a preferred Topical Antifungal Agent or Topical Corticosteroids Agent within the previous 6 months (as outlined above in question 3 of the Clinical Information section)	

Renewal Information

(attach supporting documentation, **required**)

Note: Using samples to initiate therapy does not meet renewal authorization requirements

• Has the patient previously met the required criteria set forth in Initial Approval Section above? ○ Previous Approved Prior Authorization Number: _____ ○ Approval Dates: _____	□ Yes □ No
• Patients' clinical response to treatment and ongoing safety has been documented and monitored	□ Yes □ No
• Prescriber attests that the patient has a continued need for therapy and patient is compliant with current therapy regimen	□ Yes □ No
• **For Non-Preferred Generic CALCITRIOL Ointment Requests when a Therapeutically Equivalent Brand VECTICAL Ointment is Preferred:** Provider must provide a documented medical reason the preferred formulation cannot be used: _____	

Please Note: Pharmacies should not be contacting prescribers to provide pre-signed PA forms or submitting pre-signed forms for PA, nor should prescribing providers be requesting that pharmacies perform PA activities for them. PA requests must originate from the prescriber, and only the prescriber should sign the form at the time of PA submission.
I certify that documentation is maintained in my files and the information given is true and accurate for the medication requested, subject to penalty under section 17b-99 of the Connecticut General Statutes and sections 17-83k-1- to 17-83k-7, inclusive, of the Regulations of Connecticut State Agencies. I certify that the above-referenced member is a patient under my clinic's/practice's ongoing care. I understand that a prior authorization may not exceed one (1) year from the date of fill for non- controlled medications. Authorizations for Early Refill Requests are valid one time only.

Prescriber Signature* :_____ **Date (MM/DD/CCYY)**_____

* Mandatory (others may not sign for prescriber). **In accordance with federal law, prescribers must be enrolled in the Connecticut Medical Assistance Program (CMAP). CMAP will not pay for prescriptions written by a non-enrolled provider.**