South Dakota Department of Social Services

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
Mon-Sat: 7am to 7pm Central

Zoryve® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Plaque psoriasis
❑ Seborrheic dermatitis
❑ Diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Does the patient have moderate to severe liver impairment (Child-Pugh B or C)? ❑ **Yes** ❑ **No**

Has the patient had a documented trial of one or more of the following?:

- Corticosteroid (e.g., betamethasone, clobesatol) ❑ **Yes** ❑ **No** List _____
- Vitamin D analogs (e.g., calcitriol, calcipotriene) ❑ **Yes** ❑ **No** List _____
- Tazarotene ❑ **Yes** ❑ **No**
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus) ❑ **Yes** ❑ **No** List _____
- Anthralin ❑ **Yes** ❑ **No**
- Coal tar ❑ **Yes** ❑ **No**
- Cominbation topical therapy (e.g., vitamin D analog/corticosteroid) ❑ **Yes** ❑ **No** List _____
- Topical antifungals (ketoconazole, ciclopirox, miconazole, clotrimazole) ❑ **Yes** ❑ **No** List _____

How long has the patient tried the above listed medication(s)? _____

When did the patient try the above listed medication(s) _____

Quantity limit requests:

What is the quantity requested per MONTH? _____

What is the reason for exceeding the plan limitations?

❑ Titration or loading dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-844-403-1029.