iowa total care | Iowa Health Link Iowa HHS | Hawki Iowa HHS

Fax Completed Form To
1.833.404.2392
Prescriber Help Desk
1.833.587.2012
Online
covermymeds.com/main/prior-authorization-forms/

Request for Prior Authorization
Select Topical Agents

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization (PA) is required for select topical agents. Payment for a non-preferred agent will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following criteria are met:

1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
2. Patient has a diagnosis of plaque psoriasis with involvement estimated to affect ≤ 20% of the body surface area; and
    a. Request is for roflumilast 0.3% cream or tapinarof 1% cream; and
    b. Patient has documentation of an adequate trial and therapy failure of combination therapy with a preferred medium to high potency topical corticosteroid and a preferred topical vitamin D analog for a minimum of 4 consecutive weeks; or
3. Patient has a diagnosis of seborrheic dermatitis; and
    a. Request is for roflumilast 0.3% foam; and
    b. Patient has documentation of an adequate trial and therapy failure of combination therapy with a preferred topical corticosteroid (scalp-medium to high potency or nonscalp-low potency) and preferred topical antifungal for a minimum of 4 consecutive weeks; or
4. Patient has a diagnosis of mild to moderate atopic dermatitis; and
    a. Request is for roflumilast 0.15% cream or tapinarof 1% cream; and
    b. Patient has failed to respond to good skin care and regular use of emollients; and
    c. Patient has documentation of an adequate trial and therapy failure with one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; or
    d. Patient has documentation of an adequate trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks.

The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Non-Preferred

☐ Vtama ☐ Zoryve

Strength	Usage Instructions	Quantity	Day's Supply

Diagnosis: _____

Plaque Psoriasis

Preferred Medium to High Potency Topical Corticosteroid Trial:

Drug name & dose: _____ Trial dates: _____

Failure reason: _____

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Preferred Topical Vitamin D Analog Trial:
Drug name & dose:_____ Trial dates:_____
Failure reason:_____

Is affected area estimated to affect ≤ 20% body surface area? ☐ Yes ☐ No

☐ **Seborrheic Dermatitis**

Preferred Topical Corticosteroid Trial: ☐ Scalp ☐ Nonscalp
Drug name & dose:_____ Trial dates:_____
Failure reason:_____

Preferred Topical Antifungal Trial:
Drug name & dose:_____ Trial dates:_____
Failure reason:_____

☐ **Mild to moderate atopic dermatitis**

Preferred Medium to High Potency Topical Corticosteroid Trial:
Drug name & dose:_____ Trial dates:_____
Failure reason:_____

Preferred Topical Immunomodulator Trial:
Drug name & dose:_____ Trial dates:_____
Failure reason:_____

Has patient failed to respond to good skin care and regular use of emollients? ☐ Yes ☐ No

Medical or contraindication reason to override trial requirements:_____
_____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.*