|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [Payer name:] |  | RE: | [Patient name:] |  |
| [Address:] |  |  | [Member ID:] |  |
| [Phone:] |  |  | [Policy group:] |  |
| [Fax:] |  |  | [Date of birth:] |  |
|  |  |  |  | (mm/dd/yyyy) |

[Date]

Attn: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am contacting you as a healthcare provider caring for [patient name] regarding the patient’s diagnosis of [diagnosis (ICD-10 code)].

I recently prescribed this patient ZORYVE® (roflumilast) cream, 0.3%, which required a prior authorization that was filed on [date]. The prior authorization was denied, and the patient was unable to fill their prescription. I have reviewed the patient’s diagnosis, care plan, and clinical guidelines for treatment and ***request a formal appeal of your denial for ZORYVE***.

I believe that treatment with ZORYVE is medically necessary for [Patient Name]. ZORYVE is indicated for topical treatment of plaque psoriasis, including intertriginous areas, in adult and pediatric patients 6 years of age and older.

Patient’s Medical History and Treatment Rationale: [You may want to consider including the following information, depending on your patient’s history of treatment with ZORYVE and the insurer’s reasons for denial.]

* [Patient’s history, diagnosis, current condition (eg, signs, symptoms), and previous therapies (if any)
* Patient's response to previous therapies and reasons for discontinuations (if any)
* Rationale for prescribing ZORYVE and, if applicable, dates of ZORYVE initiation and last refill, as well as the rationale for delays in refills (if any)
* Summary of your professional opinion and potential prognosis for treatment with ZORYVE, or the clinical response to ZORYVE treatment and impact on patient’s daily life]

When treating a patient with [diagnosis (ICD-10 code)], it is necessary to have access to the full spectrum of accepted

treatments, as patients may not be able to use one particular treatment due to lack of response. There is a potential for side effects like an allergic reaction. Based on the information provided above, I believe it is medically necessary for my patient to be treated with ZORYVE.

Additionally, I request that you review the following evidence showing how this medication can be effectively utilized to treat [diagnosis (ICD-10 code)]:

1. Lebwohl MG, Kircik LH, Moore AY, et al. Effect of Roflumilast Cream vs Vehicle Cream on Chronic Plaque Psoriasis: The

DERMIS-1 and DERMIS-2 Randomized Clinical Trials. JAMA. 2022;328(11):1073-1084. doi:10.1001/jama.2022.15632

On behalf of [Patient Name], I would appreciate your prompt reconsideration of this denial. Please feel free to contact me at [prescriber’s phone number] for any additional information you may require. I look forward to receiving your response and

approval of coverage for this medication.

Sincerely,

[Prescriber]

[Prescriber Title/Contact Info]

Please see INDICATION and IMPORTANT SAFETY INFORMATION.

**INDICATION**

ZORYVE (roflumilast) cream, 0.3%, is indicated for topical treatment of plaque psoriasis, including intertriginous areas, in adult and pediatric patients 6 years of age and older.

**IMPORTANT SAFETY INFORMATION**

ZORYVE is contraindicated in patients with moderate to severe liver impairment (Child-Pugh B or C).

The most common adverse reactions (≥1%) for ZORYVE cream 0.3% include diarrhea (3.1%), headache (2.4%), insomnia (1.4%), nausea (1.2%), application site pain (1.0%), upper respiratory tract infection (1.0%), and urinary tract infection (1.0%).

Please see full [Prescribing Information](http://arcutis.com/zoryve-pi-hcp) for ZORYVE.

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