|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [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) topical foam, 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 the treatment of seborrheic dermatitis in adult and pediatric patients 9 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 to 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. Zirwas MJ, Draelos ZD, DuBois J, et al. Efficacy of roflumilast foam, 0.3%, in patients with seborrheic dermatitis: a double-blind, vehicle-controlled phase 2a randomized clinical trial. *JAMA Dermatol.* 2023;159(6):613-620.
2. Blauvelt A, Draelos ZD, Stein Gold L, et al. Roflumilast foam 0.3% for adolescent and adult patients with seborrheic dermatitis: a randomized, double-blinded, vehicle-controlled, phase 3 trial. *J Am Acad Dermatol*. 2024;20:S0190-9622(24)00107-5.

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 on the next page.

**INDICATION**

ZORYVE (roflumilast) foam, 0.3%, is indicated for the treatment of seborrheic dermatitis in adult and pediatric patients 9 years of age and older.

**IMPORTANT SAFETY INFORMATION**

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

**Flammability:** The propellants in ZORYVE are flammable. Avoid fire, flame, and smoking during and immediately following application.

The most common adverse reactions (≥1%) include nasopharyngitis (1.5%), nausea (1.3%), and headache (1.1%).

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

© 2024 Arcutis Biotherapeutics, Inc.  All rights reserved.

US-COM-154-00167 03/24