HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Zoryve 0.3% Foam - Non-PDL

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Member Name:	Prescriber Name:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Member Primary Phone:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	
HPP's maximum approval time is 12 months but may be less depending on the drug.		

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is the request for reauthorization of Zoryve 0.3% foam? If YES, go to 7.

☐ Yes ☐ No

Q2. Does the patient have a diagnosis of seborrheic dermatitis?

☐ Yes ☐ No

Q3. Is the patient age appropriate according to the FDA approved package labeling?

☐ Yes ☐ No

Q4. Is the medication prescribed by or in consultation with a dermatologist?

☐ Yes ☐ No

Q5. Does the patient have severe liver impairment (Child Pugh class B or C)?

☐ Yes ☐ No

Q6. Does the patient have a history of therapeutic failure, intolerance to, or contraindication to at least a 4-week trial of two of the following: one topical corticosteroid, one topical antifungal, or

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one topical calcineurin inhibitor (such as betamethasone, hydrocortisone, ketoconazole, ciclopirox, tacrolimus ointment, Elidel cream)?

☐ Yes ☐ No

Q7. Does the patient continue to need Zoryve 0.3% foam and meet the criteria identified for initial approval?

☐ Yes ☐ No

Q8. Does the patient tolerate the medication without significant or serious side effects (must attach documentation)?

☐ Yes ☐ No

Q9. Has the patient had an improvement in symptoms from baseline (must attach documentation)?

☐ Yes ☐ No

Q10. Additional Information

Prescriber Signature

Date

v2025