UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2024 P 1395-5
Program	Prior Authorization/Notification
Medication	Zoryve® (roflumilast)
P&T Approval Date	9/2022, 9/2023, 11/2023, 2/2024, 12/2024
Effective Date	3/1/2025

1. Background:

Zoryve (roflumilast) 0.3% cream is a phosphodiesterase 4 inhibitor indicated for topical treatment of plaque psoriasis, including intertriginous areas, in patients 6 years of age and older. Zoryve (roflumilast) foam is indicated for the treatment of seborrheic dermatitis in adult and pediatric patients 9 years of age and older. Zoryve (roflumilast) 0.15% cream is indicated for the topical treatment of mild to moderate atopic dermatitis in adult and pediatric patients 6 years of age and older.

2. Coverage Criteria[a]:

A. Plaque Psoriasis

1. **Initial Authorization**

   a. **Zoryve 0.3% cream** will be approved based upon the following criterion:

      (1) Diagnosis of plaque psoriasis

   Authorization will be issued for 12 months.

2. **Reauthorization**

   a. **Zoryve 0.3% cream** will be approved based upon the following criterion:

      (1) Documentation of positive clinical response to therapy

   Authorization will be issued for 12 months.

B. Seborrheic Dermatitis

1. **Initial Authorization**

   a. **Zoryve foam** will be approved based upon the following criterion:

      (1) Diagnosis of seborrheic dermatitis

   Authorization will be issued for 12 months.

2. **Reauthorization**

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a. **Zoryve foam** will be approved based upon the following criterion:

(1) Documentation of positive clinical response to therapy

Authorization will be issued for 12 months.

C. Atopic Dermatitis

1. **Initial Authorization**

a. **Zoryve 0.15% cream** will be approved based upon the following criterion:

(1) Diagnosis of mild to moderate atopic dermatitis

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Zoryve 0.15% cream** will be approved based upon the following criterion:

(1) Documentation of positive clinical response to therapy

Authorization will be issued for 12 months.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits, Medical Necessity, and/or Step Therapy may be in place.

4. References:

1. Zoryve cream [package insert]. Westlake Village, CA: Arcutis Biotherapeutics, Inc.; July 2024.
2. Zoryve foam [package insert]. Westlake Village, CA: Arcutis Biotherapeutics, Inc.; December 2023.

Program	Prior Authorization/Notification – Zoryve (tapinarof)
Change Control	
9/2022	New program.
9/2023	Annual review with no change to clinical criteria.

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11/2023	Updated background to include patients 6 years of age and older. Updated reference.
2/2024	Added criteria for Zoryve foam for seborrheic dermatitis. Updated background and reference.
12/2024	Added criteria for Zoryve 0.15% cream for atopic dermatitis. Updated plaque psoriasis criteria to specify 0.3% cream. Updated all authorizations to 12 months. Updated background and reference.

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