Highmark Wholecare
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

I. Requirements for Prior Authorization of Antipsoriatics, Topical

A. Prescriptions That Require Prior Authorization

Prescriptions for Antipsoriatics, Topical that meet the following conditions must be prior authorized:

1. A non-preferred Antipsoriatic, Topical. See Preferred Drug List (PDL) for the list of preferred Antipsoriatics, Topical at: https://papdl.com/preferred-drug-list.

2. A topical aryl hydrocarbon receptor (AhR) agonist (e.g., tapinarof).

3. A topical phosphodiesterase type 4 (PDE4) inhibitor (e.g., roflumilast).

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for an Antipsoriatic, Topical, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. Is prescribed the Antipsoriatic, Topical for the treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication; **AND**

2. Is age-appropriate according to FDA-approved package labeling, national compendia, or peer-reviewed medical literature; **AND**

3. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

4. Does not have a contraindication to the prescribed drug; **AND**

5. For a topical AhR agonist (e.g., tapinarof), **both** of the following:

    a. **One** of the following:

        i. For treatment of atopic dermatitis, see the Immunomodulators, Dermatologics policy,

ii. For treatment of psoriasis, has a history of therapeutic failure of or a contraindication or an intolerance to **both** of the following:

a) A four-week trial of a topical corticosteroid approved or medically accepted for the treatment of the beneficiary's diagnosis

b) An eight-week trial of a non-steroidal topical pharmacologic product approved or medically accepted for the treatment of the beneficiary's diagnosis (e.g., topical calcineurin inhibitor, topical retinoid, topical vitamin D analog),

iii. For treatment of all other diagnoses, has a history of therapeutic failure of or a contraindication or an intolerance to first line therapy(ies) if applicable according to consensus treatment guidelines

b. For a non-preferred topical AhR agonist, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred topical AhR agonists approved or medically accepted for the beneficiary's diagnosis;

AND

6. For a topical PDE4 inhibitor (e.g., roflumilast), **both** of the following:

a. **One** of the following:

i. For treatment of atopic dermatitis, see the Immunomodulators, Dermatologics policy,

ii. For treatment of psoriasis, has a history of therapeutic failure of or a contraindication or an intolerance to topical calcipotriene,

iii. For treatment of seborrheic dermatitis, has a history of therapeutic failure of or a contraindication or an intolerance to at least **one** of the following:

a) A four-week trial of a topical antifungal approved or medically accepted for the treatment of the beneficiary's diagnosis,

b) A four-week trial of a topical corticosteroid approved or medically accepted for the treatment of the beneficiary's diagnosis,

c) A four-week trial of a topical calcineurin inhibitor approved or medically accepted

for the treatment of the beneficiary's diagnosis,

iv. For treatment of all other diagnoses, has a history of therapeutic failure of or a contraindication or an intolerance to first line therapy(ies) if applicable according to consensus treatment guidelines

b. For a non-preferred topical PDE4 inhibitor, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred topical PDE4 inhibitors approved or medically accepted for the beneficiary's diagnosis;

AND

2. For all other non-preferred Antipsoriatics, Topical, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Antipsoriatics, Topical approved or medically accepted for the treatment of the beneficiary's diagnosis; **AND**

NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

FOR RENEWALS OF PRIOR AUTHORIZATION FOR ANTIPSORIATICS, TOPICAL: The determination of medical necessity of a request for renewal of a prior authorization for an Antipsoriatics, Topical that was previously approved will take into account whether the beneficiary:

1. Has documentation of a positive clinical response to the prescribed drug; **AND**

2. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

3. For a non-preferred topical AhR agonist, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred topical AhR agonists approved or medically accepted for the beneficiary's diagnosis; **AND**

4. For a non-preferred topical PDE4 inhibitor, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred topical PDE4 inhibitors approved or medically accepted for the beneficiary's diagnosis; **AND**

5. For all other non-preferred Antipsoriatics, Topical, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Antipsoriatics, Topical approved or medically accepted for the treatment of the beneficiary's diagnosis;

NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

B. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for an Antipsoriatic, Topical. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

Highmark Wholecare
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

ANTIPSORIATICS, TOPICAL PRIOR AUTHORIZATION FORM *(form effective 1/5/2026)*

☐New request ☐Renewal request	Total pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Strength:	
Dose/directions:	Quantity:	Refills:
Diagnosis *(submit documentation)*:	Dx code (*required*):	

Complete all sections that apply to the beneficiary and this request.
Check all that apply and submit documentation for each item.

INITIAL requests

1. For a TOPICAL AhR AGONIST (eg, Vtama):

☐**For the treatment of PSORIASIS,** tried and failed or cannot try (due to a contraindication or an intolerance) to BOTH of the following:
- ☐A 4-week trial of a topical corticosteroid
- ☐An 8-week trial of a non-steroidal topical drug (eg, topical calcineurin inhibitor, topical retinoid, topical vitamin D analog)

☐**For the treatment of ALL OTHER diagnoses,** list other treatments tried (including start/stop dates, dose, outcomes, etc.):

_____

2. For a TOPICAL PDE4 INHIBITOR (eg, Zoryve):

☐**For the treatment of PSORIASIS:**
- ☐Tried and failed or cannot try (due to a contraindication or an intolerance) topical calcipotriene

☐**For the treatment of SEBORRHEIC DERMATITIS,** tried and failed or cannot try (due to a contraindication or an intolerance) at least ONE of the following:
- ☐A 4-week trial of a topical antifungal
- ☐A 4-week trial of a topical corticosteroid
- ☐A 4-week trial of a topical calcineurin inhibitor (eg, pimecrolimus, tacrolimus)

☐**For the treatment of ALL OTHER diagnoses,** list other treatments tried (including start/stop dates, dose, outcomes, etc.):

_____

3. For all other NON-PREFERRED Antipsoriatics, Topical (eg, vitamin D derivatives):

☐Tried and failed or has a contraindication or an intolerance to the preferred Antipsoriatics, Topical *(Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*

Highmark Wholecare
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

RENEWAL requests

1. For a TOPICAL PDE4 INHIBITOR (eg, Zoryve):

☐ Has documented evidence of a positive clinical response

2. For a TOPICAL AhR AGONIST (eg, Vtama):

☐ Has documented evidence of a positive clinical response

3. For all other NON-PREFERRED Antipsoriatics, Topical (eg, vitamin D derivatives):

☐ Has documented evidence of a positive clinical response

☐ Tried and failed or has a contraindication or an intolerance to the preferred Antipsoriatics, Topical *(Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber Signature:	**Date**: