



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

Prior authorization guidelines for **Antipsoriatics, Topical** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at <https://www.pa.gov/agencies/dhs/resources/for-providers/ma-for-providers/pharmacy-services>.

<input type="checkbox"/> New request	<input type="checkbox"/> 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 (<i>submit documentation</i>):	DX code (<i>required</i>):	

**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.)

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 TO DHS – PHARMACY DIVISION

Prescriber Signature:

Date:

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