HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Antipsoriatics - Topical

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. The request is for renewal of the Antipsoriatics, topical that was previously approved. If YES, go to 14. If NO, go to 2.

☐ Yes ☐ No

Q2. The member meets ALL of the following:

☐ 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

☐ Is age-appropriate according to FDA-approved package labeling, national compendia, or peer-reviewed medical literature

☐ Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

☐ Does not have a contraindication to the prescribed drug

Q3. What type of drug is being requested?

☐ For a topical AHR agonist, go to 4.
☐ For a topical PDE4 Inhibitor, go to 8.
☐ For all other non-preferred Antipsoriatics, Topical, go to 13.

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Q4. For a TOPICAL AHR AGONIST (e.g., tapinarof), for treatment of PSORIASIS, has a history of therapeutic failure of or a contraindication or an intolerance to BOTH of the following:

If YES, go to 6. If NO, go to 5.

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

☐ 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)

Q5. For a TOPICAL AHR AGONIST (e.g., tapinarof), 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.

☐ Yes ☐ No

Q6. The request is for a PREFERRED TOPICAL AHR AGONIST.

☐ Yes ☐ No

Q7. 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.

☐ Yes ☐ No

Q8. For a TOPICAL PDE4 INHIBITOR (e.g., roflumilast) for treatment of PSORIASIS, has a history of therapeutic failure of or a contraindication or an intolerance to topical calcipotriene. If YES, go to 11. If NO, go to 9.

☐ Yes ☐ No

Q9. For a TOPICAL PDE4 INHIBITOR (e.g., roflumilast) 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 four-week trial of a topical antifungal approved or medically accepted for the treatment of the beneficiary's diagnosis,

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

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

Q10. For a TOPICAL PDE4 INHIBITOR (e.g., roflumilast) 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.

☐ Yes ☐ No

Q11. The request is for a PREFERRED TOPICAL PDE4 INHIBITOR.

☐ Yes ☐ No

Q12. 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.

☐ Yes ☐ No

Q13. 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;

☐ Yes ☐ No

Q14. The member has documentation of a positive clinical response to the prescribed drug.

☐ Yes ☐ No

Q15. The member is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

☐ Yes ☐ No

Q16. 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.

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☐ Yes ☐ No

Q17. 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.

☐ Yes ☐ No

Q18. 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.

☐ Yes ☐ No

Q19. Additional Information:

Prescriber Signature

Date

v2026