ZORYVE™ Prescription Form
(roflumilast) cream 0.3%

ZORYVEdirect
Patient access support made easy

This form can be used unless a different form is required by state law. Prescribers are responsible for determining what is required under applicable state law.

Prescriber Information

Prescriber Name:_____ NPI #:_____ DEA #:_____

Address:_____ City:_____ State:_____ Zip:_____

Prescriber Office Contact Name:_____ Prescriber Phone: (____)_____ Prescriber Fax: (____)_____

Patient Information

Patient Name:_____ Date of Birth:_____ Sex: ☐ Male ☐ Female

Address:_____ City:_____ State:_____ Zip:_____

Cell Phone: (____)_____ Email:_____ Preferred Contact: ☐ Text ☐ Phone ☐ Email

Attach a copy of the front and back of the patient's prescription benefit card

ZORYVE Prescription Order Form			
Strength/Form	**Quantity**	**Refills**	**Administration Instructions**
ZORYVE 0.3% 60g			

ICD-10:_____

Prior Medication Trials and Failures	
Potential Treatments[1]	**Tried and Failed**
Topical corticosteroids	☐
Topical vitamin D analogs	☐
Topical retinoids	☐
Topical salicylic acid	☐
Topical anthralin	☐
Other _____	☐

Special Treatment Locations	
Potential Treatment Location	
Face	☐
Genitals	☐
Intertriginous areas	☐
Other _____	☐

Submit to a ZORYVE Direct pharmacy:

☐ **Carepoint**
www.carepoint.pharmacy
NCPDP: 1487330
Phone: 855-237-9112
Fax: 855-237-9113

☐ **Phil**
www.phil.us
NCPDP: 3685508
Phone: 855-977-0975
Fax: 888-975-0603

I certify that the above information is accurate.

Prescriber Signature:_____ Date:_____

Please complete per your state regulations

Do Not Substitute/Dispense as Written:_____ Date:_____

1. Menter et al. *J Am Acad Dermatol*. 2009;60(4):643-659.

ARCUTIS BIOTHERAPEUTICS

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(roflumilast) cream 0.3%

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Checklist to facilitate patient access to ZORYVE and avoid delays in starting treatment as prescribed:

- ☐ Confirm the prescription form is complete and has no missing information
- ☐ Include a copy of both sides of the patient insurance card(s)
- ☐ Select medications that the patient has tried and failed, if applicable
- ☐ Note special treatment location(s) (eg, facial, genital, or intertriginous areas)
- ☐ Remind the patient to respond to phone calls or text messages from the **ZORYVE Direct** pharmacy

Carepoint™
Phone: 855-237-9112
Text: 87514

phil
Phone: 855-977-0975
Text: 744-579

INDICATION

ZORYVE is indicated for topical treatment of plaque psoriasis, including intertriginous areas, in patients 12 years of age and older.

IMPORTANT SAFETY INFORMATION

The use of ZORYVE is contraindicated in patients with moderate to severe liver impairment (Child-Pugh B or C).

The most common adverse reactions (≥1%) include diarrhea (3%), headache (2%), insomnia (1%), nausea (1%), application site pain (1%), upper respiratory tract infection (1%), and urinary tract infection (1%).

Please see full Prescribing Information for ZORYVE.

COM-ARQ-151-2100007 v1.0 08/2022

ARCUTIS BIOTHERAPEUTICS