



Vtama Prior Authorization

Drug Applied:	Vtama 1% (tapinarof) cream
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Criteria:

Drug Applied will be approved when the requested medication is being used for an FDA approved indication and all of the following criteria are met:

I. Initial Therapy Criteria

A. **Plaque Psoriasis** as indicated by chart notes within the past 120 days

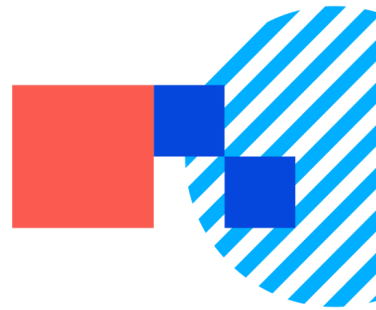
1. Patient has plaque psoriasis with affected body surface area (BSA) less than or equal to 20% **and**
2. Patient has tried and had an inadequate response to a topical corticosteroid for a minimum of 4 weeks **and**
3. Patient has tried and had an inadequate response to another topical psoriasis agent with a different mechanism of action (e.g., vitamin D analogs, tazarotene) for a minimum of 4 weeks **or**
4. Patient has an intolerance to both therapies **and**
5. Patient has tried and had an inadequate response to Zoryve 0.3% for a minimum of 4 weeks **and**
6. Prescriber is a specialist or has consulted with a specialist in the area of the patient's diagnosis (e.g., dermatology)

Approval Duration: 4 months

B. **Atopic Dermatitis** as indicated by chart notes within the past 120 days

1. Patient has atopic dermatitis with affected body surface area (BSA) less than or equal to 20% **and**
2. Patient has tried and had an inadequate response to a mid-potency or stronger topical corticosteroid for a minimum of 4 weeks **and**
3. Patient has tried and had an inadequate response to a topical calcineurin inhibitor (e.g., pimecrolimus, tacrolimus) for a minimum of 6 weeks **or**
4. Patient has an intolerance to both therapies **and**
5. Patient has tried and had an inadequate response to Zoryve 0.15% or Eucrisa for a minimum of 4 weeks **and**
6. Prescriber is a specialist or has consulted with a specialist in the area of the patient's diagnosis (e.g., dermatology)

Approval Duration: 4 months



II. Continued Therapy Criteria

A. Plaque Psoriasis as indicated by chart notes within the past 12 months

1. Patient meets the initial therapy criteria above **and**
2. Patient has had clinical benefit with the requested agent

Approval Duration: 4 months

B. Atopic Dermatitis as indicated by chart notes within the past 12 months

1. Patient meets the initial therapy criteria above **and**
2. Patient has had clinical benefit with the requested agent

Approval Duration: 4 months

Policy Owned by: Curative PBM team