curative

Vtama Prior Authorization Drug List A

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

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 moderate-potency or stronger 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: 12 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 is at least 2 years of age **and**
3. Patient has tried and had an inadequate response to a moderate-potency or stronger topical corticosteroid for a minimum of 4 weeks **and**
4. Patient has tried and had an inadequate response to a topical calcineurin inhibitor (e.g., pimecrolimus, tacrolimus) for a minimum of 6 weeks **or**
5. Patient has an intolerance to both therapies **and**
6. Patient has tried and had an inadequate response to Zoryve 0.15% or Eucrisa for a minimum of 4 weeks **and**
7. Prescriber is a specialist or has consulted with a specialist in the area of the patient's diagnosis (e.g., dermatology)

Approval Duration: 12 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: 12 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: 12 months

References:

1. Vtama prescribing information. Organon. May 2025.
2. Elmets, Craig A. et al. Joint AAD–NPF Guidelines of care for the management and treatment of psoriasis with topical therapy and alternative medicine modalities for psoriasis severity measures. Journal of the American Academy of Dermatology, Volume 84, Issue 2, 432 - 470. Feb 2021.
3. Chu, Derek K. et al. Atopic dermatitis (eczema) guidelines: 2023 American Academy of Allergy, Asthma and Immunology/American College of Allergy, Asthma and Immunology Joint Task Force on Practice Parameters GRADE– and Institute of Medicine–based recommendations. Annals of Allergy, Asthma & Immunology, Volume 132, Issue 3, 274 - 312. March 2024.
4. Sidbury, Robert et al. Guidelines of care for the management of atopic dermatitis in adults with topical therapies. Journal of the American Academy of Dermatology, Volume 89, Issue 1, e1 - e20. July 2023.
5. Davis DMR, Frazer-Green L, Alikhan A, et al. Focused update: Guidelines of care for the management of atopic dermatitis in adults with phototherapy and systemic therapies. *J Am Acad Dermatol.* 2025;93(3):e745-e747. doi:10.1016/j.jaad.2025.02125-5

Policy Owned by: Curative PBM team