PRIOR AUTHORIZATION CRITERIA

BRAND NAME*
(generic)

VTAMA
(tapinarof)

Status: CVS Caremark® Criteria
Type: Initial Prior Authorization with Quantity Limit ***Ref # 5478-C***

** Drugs that are listed in the target drug box include both brand and generic and all dosage forms and strengths unless otherwise stated. OTC products are not included unless otherwise stated.*

FDA-APPROVED INDICATIONS

Vtama (tapinarof) cream, 1% is an aryl hydrocarbon receptor agonist indicated for the topical treatment of plaque psoriasis in adults.

COVERAGE CRITERIA

Plaque Psoriasis
Authorization may be granted when the requested drug is being prescribed for the treatment of plaque psoriasis when ALL of the following criteria are met:

- The patient meets ONE of the following:
  - The patient as experienced an inadequate treatment response, intolerance OR the patient has a contraindication to a topical steroid
  - The requested drug will be used on sensitive skin areas (e.g., face, genitals, or skin folds)
- If additional quantities are being requested, then the requested drug is being prescribed to treat a body surface area that requires MORE than 60 grams per month

CONTINUATION OF THERAPY

Plaque Psoriasis
Authorization may be granted when the requested drug is being prescribed for the treatment of plaque psoriasis when ALL of the following criteria are met:

- The patient has achieved or maintained a positive clinical response to the requested drug (e.g., clear, or almost clear outcome, patient satisfaction, etc.)
- If additional quantities are being requested, then the requested drug is being prescribed to treat a body surface area that requires MORE than 60 grams per month

QUANTITY LIMITS APPLY

60 grams per 25 days* or 180 grams per 75 days*
For body surface areas requiring more than 60 grams per month: 120 grams per 25 days* or 360 grams per 75 days*
**The duration of 25 days is used for a 30-day fill period and 75 days is used for a 90-day fill period to allow time for refill processing.*

DURATION OF APPROVAL (DOA)

- 5478-C: Initial therapy DOA: 4 months; Continuation of therapy DOA: 12 months

REFERENCES

1. Vtama [package insert]. Long Beach, CA: Dermavant Sciences Inc.; May 2022.

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4. Menter A, Cordoro K, Davis D, et al. Guidelines of Care for the Management and Treatment of Psoriasis in Pediatric Patients. *J Am Acad Dermatol.* 2020;82(1):161-201.
5. Elmets C, Korman N, Farley Prater E, et al. Guidelines of Care for the Management and Treatment of Psoriasis with Topical Therapy and Alternative Medicine Modalities for Psoriasis Severity Measures. *J Am Acad Dermatol*. 2021; 84 (2):432-470.
6. Eichenfield L, Tom W, Berger T, et al. Guidelines of care for the management of atopic dermatitis: Section 2. Management and treatment of atopic dermatitis with topical therapies. *J Am Acad Dermatol*. 2014;71:116-32.
7. U.S. Department of Health & Human Services. Burn Triage and Treatment – Thermal Injuries. Chemical Hazards Emergency Medical Management. February 12, 2024. Available at: https://chemm.hhs.gov/burns.htm. Accessed June 4, 2024.

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Reviewed: Medical Affairs (CHART) 06/23/2022, 06/29/2023, 06/27/2024
External Review: 08/2022, 08/2023, 09/2024

CRITERIA FOR APPROVAL

1	Is the requested drug being prescribed for the treatment of plaque psoriasis? [If Yes, then go to 2. If No, then no further questions.]	Yes	No
2	Is the request for continuation of therapy? [If Yes, then go to 3. If No, then go to 6.]	Yes	No
3	Has the patient achieved or maintained a positive clinical response to the requested drug (e.g., clear, or almost clear outcome, patient satisfaction, etc.)? [If Yes, then go to 4. If No, then no further questions.]	Yes	No
4	Is the requested drug being prescribed to treat a body surface area that requires MORE than 60 grams per month? [If Yes, then go to 5. If No, then no further questions.]	Yes	No
5	Does the patient require MORE than the plan allowance of 120 grams per month? [No further questions] RPH Note: If yes, then deny and enter a partial approval for 120 grams per 25 days OR 360 grams per 75 days.	Yes	No
6	Has the patient experienced an inadequate treatment response, intolerance or does the patient have a contraindication to a topical steroid? [If Yes, then go to 8. If No, then go to 7.]	Yes	No
7	Is the requested drug being used on sensitive skin areas (e.g., face, genitals, or skin folds)? [If Yes, then go to 8. If No, then no further questions.]	Yes	No

8	Is the requested drug being prescribed to treat a body surface area that requires more than 60 grams per month? [If Yes, then go to 9. If No, then no further questions.]	Yes	No
9	Does the patient require MORE than the plan allowance of 120 grams per month? [No further questions] RPH Note: If yes, then deny and enter a partial approval for 120 grams per 25 days OR 360 grams per 75 days.	Yes	No

Mapping Instructions			
	Yes	**No**	**DENIAL REASONS**
1.	Go to 2	Deny	Your plan only covers this drug when it is used for certain health conditions. Covered use is for psoriasis. Your plan does not cover this drug for your health condition that your doctor told us you have. We reviewed the information we had. Your request has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: Diagnosis]
2.	Go to 3	Go to 6	
3.	Go to 4	Deny	Your plan only covers this drug if it works well for you. We have denied your request because the drug did not work well for you. We reviewed the information we had. Your request has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: Efficacy]
4.	Go to 5	[PA Approved for 12 months. Approve 60 grams per 25 days* OR 180 grams per 75 days*]. Approve, 12 Months	
5.	Deny	[PA Approved for 12 months. Approve 120 grams per 25 days* OR 360 grams per 75	We have denied your request because it is for more than the amount your plan covers (quantity limit). We reviewed the information we had. We have partially approved your request for this drug up to the amount your plan covers (120 grams per month). Your request for more drug has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug

		days*]. Approve, 12 Months	policy for more details. You can also request other plan documents for your review. [Short Description: Quantity, Exceeds max limit, Partial denial]
6.	Go to 8	Go to 7	
7.	Go to 8	Deny	Your plan only covers this drug if you have tried a topical steroid, and it did not work well for you or the requested drug will be used on sensitive skin. We have denied your request because: A) You have not tried it, B) You do not have a medical reason not to take it, or C) You are not using it on sensitive skin. We reviewed the information we had. Your request has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: Step Therapy, Sensitive skin]
8.	Go to 9	[PA Approved for 4 months. Approve 60 grams per 25 days* OR 180 grams per 75 days*]. Approve, 4 Months	
9.	Deny	[PA Approved for 4 months. Approve 120 grams per 25 days* OR 360 grams per 75 days*]. Approve, 4 Months	We have denied your request because it is for more than the amount your plan covers (quantity limit). We reviewed the information we had. We have partially approved your request for this drug up to the amount your plan covers (120 grams per month). Your request for more drug has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: Quantity, Exceeds max limit, Partial denial]