PA Request Criteria

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CAREFIRST ASO
Vtama PA with Limit

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 800-294-5979 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Vtama PA with Limit.

Patient Name: _____ **Date:** 11/27/2023
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: _____ **NPI#:** **Patient Phone:** _____ **Physician Name:**
Specialty:
Physician Office Telephone:
Physician Office Address: _____

Drug Name (select from list of drugs shown)
Vtama (tapinarof)

Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: _____ **ICD Code:** _____

Comments: _____
_____
_____

Please check the appropriate answer for each applicable question.

1.	Is the requested drug being prescribed for the treatment of plaque psoriasis?	**Y** ☐	**N** ☐
2.	Has the patient experienced an inadequate treatment response, intolerance or does the patient have a contraindication to a topical steroid?	**Y** ☐	**N** ☐
3.	Is the requested drug being used on sensitive skin areas (e.g., face, genitals, or skin folds)?	**Y** ☐	**N** ☐
4.	Is the requested drug being prescribed to treat a body surface area that requires more than 60 grams per month?	**Y** ☐	**N** ☐
5.	Does the patient require more than the plan allowance of 120 grams per month?	**Y** ☐	**N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date

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