BlueCross BlueShield Federal Employee Program

VTAMA
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Vtama cream (tapinarof)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

1. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***
   ❑ **YES –** this is a PA renewal for **CONTINUATION** of therapy, please answer questions on **PAGE 2**
   ❑ **NO** – this is **INITIATION** of therapy, please answer the following questions:
2. Will the patient need more than 3 tubes every 90 days? ❑Yes***** ❑No
   ***If YES**, please specify the requested quantity: _____ tube(s) per 90 days
3. What is the patient diagnosis? ***Please select answer below:***
   ❑ Plaque psoriasis (PsO)
      a. Is there a documented baseline evaluation of the condition using the *****Physician's Global Assessment (PGA)? ❑Yes ❑No ***PGA:* https://www.jaad.org/article/S0190-9622(15)01740-5/fulltext#gr1**
      b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to **BOTH** of the following: a topical corticosteroid and a topical vitamin D analog such as calcipotriene or calcitriol? ❑Yes ❑No
   ❑ Atopic dermatitis (eczema)
      a. Does the patient have a documented baseline evaluation of their condition using one of the following scoring tools: Investigator's Static Global Assessment (ISGA) score, Eczema Area and Severity Index (EASI), Patient-Oriented Eczema Measure (POEM), or Scoring Atopic Dermatitis (SCORAD) index? ❑Yes ❑No
      b. **Age 2 to 17**: Please answer the following questions:
         i. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a topical corticosteroid? ❑Yes ❑No
         ii. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a topical calcineurin inhibitor such as Elidel (pimecrolimus) or Protopic (tacrolimus)? ❑Yes ❑No
      c. **Age 18 or older**: Please answer the following questions:
         i. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a high potency topical corticosteroid such as Amcinonide, Fluocinonide, or Halcinonide? ❑Yes ❑No
         ii. Does the patient have lesions on their face, neck, or skin folds? ❑Yes* ❑No
            ***If YES**, does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a low to medium potency topical corticosteroid? ❑Yes ❑No
         iii. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a topical calcineurin inhibitor such as Elidel (pimecrolimus) or Protopic (tacrolimus)? ❑Yes ❑No
      d. Will this medication be used in combination with another Topical Prior Authorization (PA) medication for atopic dermatitis (eczema)? ❑Yes* ❑No
         ***If YES,** please specify the medication: _____
   ❑ None of the above

BlueCross BlueShield
Federal Employee Program

VTAMA
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

CONTINUATION OF THERAPY (PA RENEWAL)

Vtama cream (tapinarof)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

1. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***
   ❑**NO** – this is **INITIATION** of therapy, please answer questions on **PAGE 1**
   ❑**YES –** this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:
2. Will the patient need more than 3 tubes every 90 days? ❑Yes***** ❑No
   ***If YES**, please specify the requested quantity: _____ tube(s) per 90 days
3. What is the patient diagnosis? ***Please select answer below:***
   ❑Plaque psoriasis (PsO)
      a. Is there a documented improvement using the *****Physician's Global Assessment (PGA)? ❑Yes ❑No
         ***PGA:** https://www.jaad.org/article/S0190-9622(15)01740-5/fulltext#gr1
   ❑Atopic dermatitis (eczema)
      a. Which scoring tool was used to obtain the patient's baseline status? ***Select scoring tool and answer the following question:***
         ❑Eczema Area and Severity Index (EASI)
            i. Does the patient have a documented improvement from baseline by at least 75%? ❑Yes ❑No
         ❑Investigator's Static Global Assessment (ISGA) score
            i. Does the patient have a documented improvement from baseline by at least 2 points? ❑Yes ❑No
         ❑Patient-Oriented Eczema Measure (POEM)
            i. Does the patient have a documented improvement from baseline by at least 3 points? ❑Yes ❑No
         ❑**Sc**oring Atopic Dermatitis (SCORAD) index
            i. Does the patient have a documented decrease from baseline by at least 50%? ❑Yes ❑No
      b. Will this medication be used in combination with another Topical Prior Authorization (PA) medication for atopic dermatitis (eczema)? ❑Yes* ❑No
         ***If YES,** please specify the medication: _____
   ❑None of the above