

UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2023 P 2286-3
Program	Prior Authorization/Medical Necessity
Medication	Vtama® (tapinarof)
P&T Approval Date	9/2022, 11/2022, 11/2023
Effective Date	2/1/2024

1. Background:

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

2. Coverage Criteria^a:

A. Initial Authorization

1. **Vtama** will be approved based on **all** of the following criteria:

a. Diagnosis of plaque psoriasis

-AND-

b. Minimum duration of a 4-week trial and failure, contraindication, or intolerance to **one** of the following topical therapies²:

- (1) Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- (2) Vitamin D analogs (e.g., calcitriol, calcipotriene)
- (3) Tazarotene
- (4) Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- (5) Anthralin
- (6) Coal tar

-AND-

c. Patient is not receiving **Vtama** in combination with a Targeted Immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

-AND-

d. Prescribed by, or in consultation with, a dermatologist

Authorization will be issued for 6 months.

B. Reauthorization

1. **Vtama** will be approved based on **both** of the following criteria:

a. Documentation of positive clinical response to therapy

-AND-

b. Patient is not receiving **Vtama** in combination with a Targeted Immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

Authorization will be issued for 12 months.

^a State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4. References:

1. **Vtama** [package insert]. Long Beach, CA: Dermavant Sciences Inc.; May 2022.
2. Elmets CA, Korman NJ, Farley Prater E, 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. *J Am Acad Dermatol* 2021;84:432-70.

Program	Prior Authorization/Medical Necessity - Vtama [®] (tapinarof)
Change Control	
9/2022	New program.
11/2022	Revised trial and failure requirement from either two topical therapies or calcipotriene and betamethasone dipropionate to a trial and failure of one topical therapy.
11/2023	Annual review. Updated not to be used in combination to Targeted Immunomodulators. Simplified reauthorization criteria to only require positive clinical response and not used in combination with other treatment medications.