UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2023 P 1394-2
Program	Prior Authorization/Notification
Medication	Vtama® (tapinarof)
P&T Approval Date	9/2022, 9/2023
Effective Date	12/1/2023

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 upon the following criterion:

   a. Diagnosis of plaque psoriasis

   Authorization will be issued for 6 months.

B. Reauthorization

1. **Vtama** will be approved based upon the following criterion:

   a. Documentation of positive clinical response to therapy

   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, Medical Necessity, and/or Step Therapy may be in place.

4. References:

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

Program	Prior Authorization/Notification – Vtama® (tapinarof)
Change Control	
9/2022	New program.
9/2023	Annual review with no change to clinical criteria.