UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2025 P 2286-5
Program	Prior Authorization/Medical Necessity
Medication	Vtama® (tapinarof)
P&T Approval Date	9/2022, 11/2022, 11/2023, 12/2024, 5/2025
Effective Date	8/1/2025

1. Background:

Vtama cream is an aryl hydrocarbon receptor agonist indicated for the topical treatment of plaque psoriasis in adults and the topical treatment of atopic dermatitis in adults and pediatric patients 2 years of age and older.[1]

2. Coverage Criteria[a]:

A. Plaque Psoriasis

1. **Initial Authorization**

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

(1) Diagnosis of plaque psoriasis

-AND-

(2) Minimum duration of a 4-week trial and failure, contraindication, or intolerance to **one** of the following topical therapies[2]:

(a) Corticosteroids (e.g., betamethasone, clobetasol, desonide)
(b) Vitamin D analogs (e.g., calcitriol, calcipotriene)
(c) Tazarotene
(d) Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
(e) Anthralin
(f) Coal tar

-AND-

(3) 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.

2. **Reauthorization**

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

(1) Documentation of positive clinical response to therapy

-AND-

(2) 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.

B. Atopic Dermatitis

1. **Initial Authorization**

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

(1) Diagnosis of atopic dermatitis

-AND-

(2) History of failure, contraindication, or intolerance to **one** of the following therapeutic classes of topical therapies:

(a) **One** of the following:
- For mild atopic dermatitis: a topical corticosteroid [e.g., DesOwen (desonide), hydrocortisone] (any potency)
- For moderate atopic dermatitis: a topical corticosteroid of at least a medium- to high-potency (e.g., Elocon (mometasone furoate), Synalar (fluocinolone acetonide), Lidex (fluocinonide)]

(b) One topical calcineurin inhibitor [e.g., Elidel (pimecrolimus), Protopic (tacrolimus)]*

-AND-

(3) Patient is **not** receiving **Vtama** in combination with a targeted immunomodulator [e.g., Adbry (tralokinumab-ldrm), Cibinqo (abrocitinib), Dupixent (dupilumab), Rinvoq (upadacitinib)]

Authorization will be issued for 12 months.

2. **Reauthorization**

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

(1) Documentation of positive clinical response to therapy

-AND-

(2) Patient is **not** receiving **Vtama** in combination with a targeted immunomodulator [e.g., Adbry (tralokinumab-ldrm), Cibinqo (abrocitinib), Dupixent (dupilumab), Rinvoq (upadacitinib)]

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.
* Elidel and Protopic/tacrolimus ointment require prior authorization.

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.; December 2024.
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.
12/2024	Annual review. Removed prescriber requirement. Updated initial authorization to 12 months.
5/2025	Added coverage criteria for atopic dermatitis. Updated background and reference.