

UnitedHealthcare Pharmacy  
Clinical Pharmacy Programs

Program Number	2024 P 1394-3
Program	Prior Authorization/Notification
Medication	Vtama® (tapinarof)
P&T Approval Date	9/2022, 9/2023, 12/2024
Effective Date	3/1/2025

**1. Background:**

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

**2. Coverage Criteria<sup>a</sup>:**

<p><b>A. <u>Initial Authorization</u></b></p> <p>1. <b><u>Vtama</u></b> will be approved based upon the following criterion:</p> <p style="padding-left: 40px;">a. Diagnosis of plaque psoriasis</p> <p style="padding-left: 80px;"><b>Authorization will be issued for 12 months.</b></p> <p><b>B. <u>Reauthorization</u></b></p> <p>1. <b>Vtama</b> will be approved based upon the following criterion:</p> <p style="padding-left: 40px;">a. Documentation of positive clinical response to therapy</p> <p style="padding-left: 80px;"><b>Authorization will be issued for 12 months.</b></p> <p><sup>a</sup> 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.</p>
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**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 <sup>®</sup> (tapinarof)
<b>Change Control</b>	
9/2022	New program.
9/2023	Annual review with no change to clinical criteria.
12/2024	Annual review. Updated initial authorization to 12 months.