

Policy Name:	Vtama (tapinarof) cream	Policy #:	3157P
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Purpose of the Policy

The purpose of this policy is to establish the criteria for coverage of Vtama (tapinarof) topical product.

Statement of the Policy

Health Alliance Medical Plans will approve the use of topical Vtama (tapinarof) under the pharmacy benefit, when the following criteria have been met:

Criteria

1. Coverage Criteria for Plaque Psoriasis

- 1.1 Diagnosis of plaque psoriasis with body surface area (BSA) \leq 20%
- 1.2 Age 18 years or older
- 1.3 Prescribed by or in consultation with a dermatologist (skin doctor) or rheumatologist (doctor of the musculoskeletal system)
- 1.4 Documented failure, intolerance, or contraindication to a high potency topical steroid
- 1.5 Documented failure, intolerance, or contraindication to calcipotriene topical OR tazarotene topical

2. Coverage Criteria for Atopic Dermatitis

- 2.1 Diagnosis of moderate to severe atopic dermatitis with body surface area (BSA) \leq 35%
- 2.2 Age 2 years or older
- 2.3 Prescribed by or in consultation with a dermatologist (skin doctor)
- 2.4 Documented failure, intolerance, or contraindication to a topical corticosteroid
- 2.5 Documented failure, intolerance, or contraindication to a topical calcineurin inhibitor (such as tacrolimus or pimecrolimus)

3. Approval Period

- 3.1 Initial authorization: 12 months
- 3.2 Subsequent authorizations: 12 months with documented clinical improvement on therapy

4. Managed Dose Limit

- 4.1 60 grams (1 tube) per 30 days

CPT Codes

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HCPCS Codes

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References

1. Vtama (tapinarof) [prescribing information]. Long Beach, CA: Dermavant Sciences Inc; December 2024.
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4. Nast A, et al. EuroGuiDerm Guideline on the systemic treatment of psoriasis vulgaris – Part 1: treatment and monitoring recommendations. *J Eur Acad Dermatol Venereol*. 2020;34(11):2461-2498.
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DISCLAIMER

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