Pharmacy Drug Policy & Procedure

Policy Name:	Vtama (tapinarof) cream	Policy #:	3157P

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) ≤ 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. Approval Period

2.1 Initial authorization: 12 months
2.2 Subsequent authorizations: 12 months with documented clinical improvement on therapy

3. Managed Dose Limit

3.1 60 grams (1 tube) per 30 days

CPT Codes

HCPCS Codes

References

1. Vtama (tapinarof) [prescribing information]. Long Beach, CA: Dermavant Sciences Inc; May 2022.
2. Lebwohl MG, Stein Gold L, Strober B, et al. Phase 3 trials of tapinarof cream for plaque psoriasis. N Engl J Med. 2021;385(24):2219-2229.
3. Strober B, et al. One-year safety and efficacy of tapinarof cream for the treatment of plaque psoriasis: results from the PSOARING 3 trial. J Am Acad Dermatol. 2022:S0190-9622(22)02219-8.
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.
5. Elmets CA, Korman NJ, Prater EF, 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 Aca Derm. 2021 Feb 1; 84(2):432-470.

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