Division: Pharmacy Policy	Subject: Prior Authorization Criteria
Original Development Date: Original Effective Date: Revision Date:	October 14, 2022 May 8, 2024

Vtama® (tapinarof)

LENGTH OF AUTHORIZATION: Up to one year

REVIEW CRITERIA:

- Patient must be ≥ 18 years of age.
- Patient must have a diagnosis of plaque psoriasis.
- Patient has had an inadequate response, intolerance, or contraindication to daily application of all the following for at least 4-weeks. *(clinical documentation demonstrating prior treatment failures must be provided)*:
  - Preferred topical corticosteroids;
  - Calcineurin inhibitors (e.g., Elidel®, Protopic®/tacrolimus);
  - Calcipotriene;
  - Zoryve.

CONTINUATION OF THERAPY

- Patient met initial review criteria.
- Documentation of improved clinical response.
- Dosing is appropriate as per labeling or is supported by compendia.

DOSING AND ADMINISTRATION:

- Refer to product labeling at https://www.accessdata.fda.gov/scripts/cder/daf/
- Available as a 1% cream.