COUPE HEALTH

PHARMACY UTILIZATION MANAGEMENT (UM) PROGRAM CRITERIA ACTIVITY

Provider Notification

Policies Effective: 1/19/2023 Notification Posted: 12/5/2022

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Revisions are effective the first of the month following a 45-day notification and comment period.

NEW UM PROGRAM CRITERIA			
Vtama (tapinarof cream 1%)			
Program Type:	☒ Prior Authorization	☒ Quantity Limit	☒ Step Therapy

Prior Authorization Approval Criteria

Vtama (tapinarof cream 1%)

Generic name: tapinarof cream
Brand name: Vtama
Medispan GPI: 902500750037** MONY
Medication class: Aryl hydrocarbon receptor (AhR) agonist
FDA-approved uses: **Plaque Psoriasis (PsO)**

Usual dose range:
PsO Apply to affected areas once daily

Duration of Authorization:
Initial: 4 months
Ongoing: 1 year

Estimated Cost: $19,080/yr (1x 60gm tube per month) AWP

Criteria for use for Plaque Psoriasis

- Submitted clinical documentation and prescription claims records must be consistent and non-contradictory to the treatment plan.
- Must be 18 years of age or older.
- Grandfather criteria allowed
  - Please see policy and procedure "*14 – Grandfather Status Authorization*" for additional information.

- Patient is clinically diagnosed with plaque psoriasis.
- Must be prescribed by, or in consultation with a board-certified dermatologist.
- Patient has failure, contraindication, or intolerance to at least:
    - ONE generic high-dose or super-high dose topical corticosteroids as appropriate for age group and location (triamcinolone, clobetasol)
      -AND-
    - ONE generic topical vitamin D analog (calcipotriene, calcitriol)
- Coverage is limited to one 60gm tube per 30 days.
    - Larger quantities requested would require a documentation of 60 grams per day would be insufficient, and standard therapy has been failed.
    - For patients with moderate to severe PsO, plan would prefer, but not require, use of oral DMARDs prior to approval of larger quantities.

Criteria continuation of therapy

- Patient is tolerating and responding to medication and there continues to be a medical need for the medication.
- Updated chart notes or other clinical documentation confirming efficacy and tolerability of the requested treatment will be required for all renewal reviews. Submitted clinical documentation must be from an encounter after the start date of the current approval.
- Patient demonstrates adequate compliance as defined as an MPR >80%.

Contraindications:

- History of hypersensitivity to any of the product ingredients.

Not approved if:

- Patient does not meet any of the above criteria.
- Patient has a contraindication to treatment.

Special Considerations:

- None reported by manufacturer at this time

References:

1. 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. doi:10.1056/NEJMoa2103629[PubMed 34879448]
2. Vtama (tapinarof) [prescribing information]. Long Beach, CA: Dermavant Sciences Inc; May 2022.

MedOne Clinical Review Subcommittee approval: Date: 11-30-22

Initial adoption: 11-30-22
Revised: 11-30-22
11-30-22 1. Pricing updated based off of AWP (11-30-22)
Effective Date (most recent revisions): 1-19-23

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exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy has been developed by licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by MedOne Pharmacy Benefits, or any of such health plan's affiliates, as applicable.