Pharmacy Medical Necessity Guidelines:
Vtama (tapinarof) topical cream

Effective: July 1, 2026

Prior Authorization Required	√	Type of Review – Care Management	
Not Covered		Type of Review – Clinical Review	√
Pharmacy (RX) or Medical (MED) Benefit	RX	Department to Review	RXUM
These pharmacy medical necessity guidelines apply to the following: ☒ Tufts Health RITogether – A Rhode Island Medicaid Plan		**Fax Numbers:** RXUM: 617.673.0939	

Note: This guideline does not apply to Medicare Members (includes dual eligible Members).

OVERVIEW

FOOD AND DRUG ADMINISTRATION INDICATION

Vtama (tapinarof) cream 1% is an aryl hydrocarbon receptor agonist indicated for the topical treatment of plaque psoriasis in adults and atopic dermatitis in adults and pediatric patients 2 years of age or older.

COVERAGE GUIDELINES

The plan may authorize coverage when the following criteria are met and limitations do not apply:

Plaque Psoriasis

1. Documented diagnosis of plaque psoriasis

AND

2. Patient is 18 year of age or older

AND

3. Documentation of one of the following:
   a. Documentation that the patient has had a trial and failure, inadequate response, or contraindication to at least two medium to very high potency topical corticosteroids (examples: betamethasone dipropionate 0.05% lotion/cream, triamcinolone 0.5% cream/ointment, betamethasone dipropionate augmented 0.05%gel/lotion/ointment)

OR

   b. Documentation that the patient is not a candidate for medium to high potency corticosteroid therapy (e.g., eyelid dermatitis, facial dermatitis, or dermatitis associated with genital area eruptions)

AND

4. Documentation that the patient has had a trial and failure, inadequate response, or contraindication to at least one topical vitamin D analog (examples: calcipotriene 0.005% cream, calcipotriene 0.005% and betamethasone dipropionate 0.064% ointment, calcitriol 3 mcg/g ointment)

5. Documentation that the patient has had a trial and failure, inadequate response, or contraindication to Zoyve (roflumilast) cream

Atopic Dermatitis

1. Documented diagnosis of atopic dermatitis

AND

2. Patient is 2 years of age or older

AND

3. Documentation of one of the following:
   a. Documentation that the patient has had a trial and failure, inadequate response, or contraindication to at least one medium to very high potency topical corticosteroids (examples: betamethasone dipropionate 0.05% lotion/cream, triamcinolone 0.5% cream/ointment, betamethasone dipropionate augmented 0.05% gel/lotion/ointment)

OR

   b. Documentation that the patient is not a candidate for medium to high potency corticosteroid therapy (e.g., eyelid dermatitis, facial dermatitis, or dermatitis associated with genital area eruptions)

AND

4. Documentation that the patient has had a trial and failure, inadequate response, or contraindication to one topical calcineurin inhibitor (examples: tacrolimus ointment, pimecrolimus cream)

AND

5. Documentation that the patient has had a trial and failure, inadequate response, or contraindication to Zoyve (roflumilast) cream

LIMITATIONS

None

CODES

None

REFERENCES

1. Davis DMR, Frazer-Green L, Alikhan A, Bercovitch L, Cohen DE, Darr JM, et al. Focused update: Guidelines of care for the management of atopic dermatitis in adults. J Am Acad Dermatol. 2025 Sep. 93 (3):745.e1-745.e7.
2. Eichenfield LF, Tom WL, Berger TG, Krol A, Paller AS, Schwarzenberger K, et al. Guidelines of care for the management of atopic dermatitis. J Am Acad Dermatol, 2014; 71, 116-132.
3. Vtama (tapinarof) topical cream [prescribing information]. Long Beach, CA: Dermavant; December 2024.

APPROVAL HISTORY

September 13, 2022: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:

1. November 14, 2023: Effective December 1, 2023, removed reauthorization criteria and updated length of treatment to life of plan. Updated RxUM fax number.
2. March 11, 2025: No changes
3. April 14, 2026: Effective July 1, 2026, added coverage criteria for atopic dermatitis based on updated package labeling. For plaque psoriasis, updated criteria to include prerequisite trial with Zoryve cream.

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.