AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Vtama® (tapainarof) **1% cream**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

Quantity Limits: 60 grams (1 tube) per 30 days

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ **Diagnosis: Atopic Dermatitis**

Initial Authorization: 6 months

- ❑ Member is ≥ 2 years of age
- ❑ Member has a diagnosis of atopic dermatitis for ≥ 3 months

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- ❑ Member has tried and failed **ALL** the following **(verified by chart notes and/or pharmacy paid claims)**:
  - ❑ At least 14 days of therapy with a topical corticosteroid (e.g., triamcinolone, mometasone, fluocinolone, fluocinonide, betamethasone)
  - ❑ At least 30 days of therapy with a topical calcineurin inhibitor (e.g., tacrolimus ointment, pimecrolimus cream)
  - ❑ At least 30 days of therapy with Eucrisa 2% ointment (*requires prior authorization)

Diagnosis: Atopic Dermatitis

Reauthorization: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member has experienced disease improvement and/or stabilization of atopic dermatitis **(chart notes must be submitted)**

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

❑ Diagnosis: Plaque Psoriasis

Initial Authorization: 6 months

- ❑ Member is ≥ 18 years of age
- ❑ Member has a diagnosis of plaque psoriasis
- ❑ Member has a history of failure, contraindication, or intolerance to **BOTH** of the following therapies **(chart notes documenting contraindication(s) or intolerance must be attached; trials will be verified by chart notes and/or pharmacy paid claims)**:
  - ❑ 30 days (14 days for very high potency) of therapy with **ONE** topical corticosteroid in the past 180 days
  - ❑ 30 days of therapy with **ONE** other topical agent used for the treatment of psoriasis (e.g., calcipotriene 0.05% ointment or solution, tacrolimus 0.01% or 0.03% ointment, tazarotene 0.1% cream) in the past 180 days

Diagnosis: Plaque Psoriasis

Reauthorization: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member has experienced disease improvement and/or stabilization of plaque psoriasis **(chart notes must be submitted)**

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Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

***Approved by Pharmacy and Therapeutics Committee**: ~~7/21/2022;~~ ~~9/15/2022 ;~~ ~~11/16/2023;~~ **1/23/2025**
REVISED/UPDATED: ~~8/5/2022;~~ ~~9/9/2022;~~ ~~10/4/2022;~~ ~~12/11/2023;~~ **02/18/2025**