Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Vtama (tapinarof) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 6 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Vtama (tapinarof).** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours (fax: 1-866-331-2104). If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____

Sig: _____

Drug 2: Name/Strength/Formulation: _____

Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, state start date: _____

2. Indicate the patient's diagnosis for the requested medication: _____

Clinical Criteria:

1. Prescriber is a Dermatologist,
   □ No □ Yes
2. **AND** patient is ≥18 years of age,
   □ No □ Yes
3. **AND** diagnosis of moderate to severe plaque psoriasis (BSA involvement >3% and <20%),
   □ No □ Yes
4. **AND** inadequate response or contraindication to at least 3-month trial of phototherapy unless involvement in sensitive areas (e.g. face, body folds, etc.),
   □ No □ Yes
5. **AND** documented history of inadequate response (≥4-weeks trial), contraindication, or intolerance to high- to super high-potency topical corticosteroids (e.g., betamethasone dipropionate 0.05% cream or ointment, triamcinolone 0.5% cream or ointment, clobetasol propionate 0.05% ointment, lotion, solution),
   □ No □ Yes
6. **AND** documented history of inadequate response (≥ 4 weeks trial), contraindication, or intolerance to at least 1 of the following topical combination regimen:
   a. High- or ultra high-potency topical corticosteroids used with topical calcitriol or calcipotriene
   b. High- or ultra high-potency topical corticosteroids used with topical tazarotene
   □ No □ Yes

For continuation of therapy, please respond to <u>additional questions</u> below:

1. Patient meets all the initial criteria for coverage,
   □ No □ Yes
2. **AND** documentation of positive clinical response
   □ No □ Yes

6 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____
_____
_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**