US Family Health Plan
Prior Authorization Request Form for
Tapinarof 1% cream (Vtama)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Prior authorization does not expire for plaque psoriasis.
Prior authorization for atopic dermatitis expires after 1 year.
nitial PA approval required for renewal. If renewal criteria met, coverage will be approved indefinitely.

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #:		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. What is the diagnosis or indication?	☐ Plaque psoriasis - Proceed to question **2** ☐ Moderate to severe atopic dermatitis – Proceed to question **5** ☐ Other diagnosis – **STOP Coverage not approved**	
2. Is the patient 18 years of age or older?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Is the requested medication prescribed by or in consultation with a dermatologist?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Has the patient tried for at least 2 weeks and failed, or had an adverse reaction to or has a contraindication to BOTH of the following: moderate to high potency topical corticosteroid (for example, clobetasol propionate 0.05% ointment, cream, solution and gel; fluocinonide 0.05% ointment, cream, solution) AND topical calcineurin inhibitor (for example, tacrolimus, pimecrolimus)?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
5. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for the requested medication.*	☐ Yes Proceed to question **13**	☐ No Proceed to question **6**
6. Is the patient 2 years of age or older?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**

7. Is the requested medication being prescribed by a dermatologist, allergist, or immunologist?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. How old is the patient?	☐ Less than 2 years old - **STOP Coverage not approved** ☐ 2 to 17 years of age – Proceed to question **9** ☐ 18 years of age or older– Proceed to question **10**	
9. Does the patient have a contraindication to, intolerability to, OR has failed treatment with any topical corticosteroid?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
10. Does the patient have a contraindication to, intolerability to, OR has failed treatment with high potency/class 1 topical corticosteroids (for example, clobetasol propionate 0.05% ointment/cream, fluocinonide 0.05% ointment/cream)?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Does the patient have a contraindication to, intolerability to, OR has failed treatment with topical calcineurin inhibitor (for example, pimecrolimus, tacrolimus)?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. Does the patient have a contraindication to, intolerability to, inability to access treatment, OR has failed treatment with Narrowband UVB phototherapy?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
13. Has the patient's disease severity improved and stabilized to warrant continued therapy?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature _____ Date _____