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**

Initial approvals expire after twelve months, renewal approvals are indefinite. For renewal of therapy, an initial USFHP prior authorization approval is required.

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. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question **2**	☐ No **STOP** Coverage not approved
2. Does the patient have a diagnosis of plaque psoriasis?	☐ Yes Proceed to question **3**	☐ No **STOP** Coverage not approved
3. Is the medication is being prescribed 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

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____

[9 November 2022]