



**AETNA BETTER HEALTH®
Coverage Policy/Guideline**

Name: Vtama

Page: 1 of 3

Effective Date: 2/2/2026

Last Review Date: 10/2025

Applies to: ☐ Illinois
☒ Florida Kids

☐ New Jersey
☒ Pennsylvania Kids

☐ Maryland
☐ Virginia

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Vtama under the patient's prescription drug benefit.

Description:

FDA-approved Indications

Plaque Psoriasis

Vtama cream is indicated for the topical treatment of plaque psoriasis in adults.

Atopic Dermatitis

Vtama cream is indicated for the topical treatment of atopic dermatitis in adults and pediatric patients 2 years of age and older.

Applicable Drug List:

Non-Preferred Agent:

Vtama

Policy/Guideline:

Coverage Criteria

Atopic Dermatitis

Authorization may be granted when the requested drug is being prescribed for the treatment of atopic dermatitis when ALL of the following criteria are met:

- The patient is unable to take the required formulary alternative Eucrisa, due to a trial and inadequate treatment response, or intolerance, or a contraindication.
- The patient is 2 years of age or older.
- The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a topical calcineurin inhibitor OR a medium or higher potency topical corticosteroid.
- If additional quantities are being requested, then the requested drug is being prescribed to treat a body surface area that requires MORE than 60 grams per month.

Plaque Psoriasis

Authorization may be granted when the requested drug is being prescribed for the treatment of plaque psoriasis when ALL of the following criteria are met:



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- The patient is unable to take a Zoryve 0.3% topical cream or 0.3% topical foam for the given diagnosis due to a trial and inadequate treatment response or intolerance, or a contraindication. Documentation is required for approval.
- The patient meets ONE of the following:
 - The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a topical steroid.
 - The requested drug will be used on sensitive skin areas (e.g., face, genitals, or skin folds).
- If additional quantities are being requested, then the requested drug is being prescribed to treat a body surface area that requires MORE than 60 grams per month.

Continuation of Therapy

Atopic Dermatitis

Authorization may be granted when the requested drug is being prescribed for the topical treatment of atopic dermatitis when ALL of the following criteria are met:

- The patient is 2 years of age or older.
- The patient has achieved or maintained a positive clinical response as evidenced by improvement (e.g., improvement in or resolution of any of the following signs and symptoms: erythema [redness], edema [swelling], xerosis [dry skin], erosions, excoriations [evidence of scratching], oozing and crusting, lichenification [epidermal thickening], OR pruritus [itching]).
- If additional quantities are being requested, then the requested drug is being prescribed to treat a body surface area that requires MORE than 60 grams per month.

Plaque Psoriasis

Authorization may be granted when the requested drug is being prescribed for the treatment of plaque psoriasis when ALL of the following criteria are met:

- The patient is unable to take a Zoryve 0.3% topical cream or 0.3% topical foam for the given diagnosis due to a trial and inadequate treatment response or intolerance, or a contraindication. Documentation is required for approval.
- The patient has achieved or maintained a positive clinical response to the requested drug (e.g., clear, or almost clear outcome, patient satisfaction, etc.).



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- If additional quantities are being requested, then the requested drug is being prescribed to treat a body surface area that requires MORE than 60 grams per month.

Approval Duration and Quantity Restrictions:

Initial Approval: Atopic Dermatitis 3 months; Plaque Psoriasis 4 months

Renewal Approval: 12 months

Quantity Level Limit: Quantity Limits Apply

- 60 grams per 30 days
- For body surface areas requiring more than 60 grams per month: 120 grams per 30 days

References:

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