| AETNA BETTER HEALTH®<br>Coverage Policy/Guideline | | | | |
|---|---|---|---|---|
| Name: | Vtama | | Page: | 1 of 3 |
| Effective Date: | 2/2/2026 | | Last Review Date: | 10/2025 |
| Applies to: | ☒Illinois<br>☐Florida Kids | ☒New Jersey<br>☐Pennsylvania Kids | ☒Maryland<br>☐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:

- 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 has achieved or maintained a positive clinical response to the requested drug (e.g., clear, or almost clear outcome, patient satisfaction, etc.).
- 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:

1. Vtama [package insert]. Long Beach, CA: Dermavant Sciences Inc.; May 2025.
2. Lexicomp Online, AHFS DI (Adult and Pediatric) Online. Waltham, MA: UpToDate, Inc.; 2025. https://online.lexi.com. Accessed June 3, 2025.
3. Micromedex® (electronic version). Merative, Ann Arbor, Michigan, USA. Available at: https://www.micromedexsolutions.com/ (cited: 06/03/2025).
4. Menter A, Cordoro K, Davis D, et al. Guidelines of Care for the Management and Treatment of Psoriasis in Pediatric Patients. J Am Acad Dermatol. 2020;82(1):161-201.
5. Elmets C, Korman N, Farley Prater E, et al. Guidelines of Care for the Management and Treatment of Psoriasis with Topical Therapy and Alternative Medicine Modalities for Psoriasis Severity Measures. J Am Acad Dermatol. 2021;84(2):432-470.
6. Eichenfield L, Tom W, Berger T, et al. Guidelines of care for the management of atopic dermatitis: Section 2. Management and treatment of atopic dermatitis with topical therapies. J Am Acad Dermatol. 2014;71:116-32.
7. Eichenfield LF, Tom WL, et. al. Guidelines of Care for the Management of Atopic Dermatitis: Section 1. Diagnosis and assessment of atopic dermatitis. J Am Acad Dermatol 2014;70:338-51.
8. Sidbury RS, Alikhan A, Berovitch L, et al. Guidelines of care for the management of atopic dermatitis in adults with topical therapies. J Am Acad Dermatol. 2023;89(1):e1-e20.
9. U.S. Department of Health & Human Services. Burn Triage and Treatment – Thermal Injuries. Chemical Hazards Emergency Medical Management. February 12, 2024. Available at: https://chemm.hhs.gov/burns.htm. Accessed May 14, 2025.
10. Davis DMR, Frazer-Green L, Alikhan A, et al. Focused update: Guidelines of care for the management of atopic dermatitis in adults. J Am Acad Dermatol. 2025;93(3):745.e1-745.e7.
11. Schoch JJ, Anderson KR, Jones AE, et al. Section on Dermatology. Atopic Dermatitis: Update on Skin-Directed Management: Clinical Report. Pediatrics. 2025;e2025071812.