AETNA BETTER HEALTH® Coverage Policy/Guideline				
Name:	Vtama		Page:	1 of 3
Effective Date:	3/26/2025		Last Review Date:	2/26/2025
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:

Criteria for Initial Approval:

Atopic Dermatitis
Authorization may be granted when the requested drug is being prescribed for the treatment of atopic dermatitis when ALL 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 meets ONE of the following:
  - The requested drug will be used on sensitive skin areas (e.g. face, genitals, or skin folds) and the following criteria is met:
    - The patient experienced an inadequate treatment response, intolerance, OR has a contraindication to a topical calcineurin inhibitor
  - The patient experienced an inadequate treatment response, intolerance, or contraindication to a topical calcineurin inhibitor AND 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 the following criteria are met:

- The patient meets ONE of the following:

  - The patient as experienced an inadequate treatment response, intolerance OR the patient 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 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 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:

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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.
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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 June 4, 2024.