TRICARE Prior Authorization Request Form for
tapinarof 1% cream **(Vtama)**

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
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FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

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]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#: