Clinical Policy Title:	roflumilast**,** tapinarof
Policy Number:	RxA.777
Drug(s) Applied:	Zoryve, Vtama
Original Policy Date:	10/19/2022
Last Review Date:	08/19/2026
Line of Business Policy Applies to:	All lines of business (except Medicare)

Criteria

I. Initial Approval Criteria

A. Plaque Psoriasis (Zoryve cream 0.3%, Vtama, Zoryve foam) (must meet all):

1. Diagnosis of plaque psoriasis;
2. Documented trial and failure of at least one (1) generic topical corticosteroid, unless contraindicated or clinically significant adverse effects are experienced.

Approval Duration

All Lines of Business (except Medicare): 12 months

B. Atopic Dermatitis (Vtama, Zoryve 0.15% cream) (must meet all):

1. Diagnosis of atopic dermatitis;
2. Documented trial and failure of both of the following, unless contraindicated or clinically significant adverse effects are experienced (a and b):
   a. Medium to high potency topical corticosteroid;
   b. Topical calcineurin inhibitor.

Approval Duration

All Lines of Business (except Medicare): 12 months

C. Seborrheic dermatitis (Zoryve foam) (must meet all):

1. Diagnosis of seborrheic dermatitis;
2. Documented trial of at least 4 weeks of two of the following topical medications from different mechanism of action, unless contraindicated or clinically significant adverse effects are experienced (a, b, c):
   a. Topical antifungal (ciclopirox or ketoconazole);
   b. Topical corticosteroid;
   c. Topical calcineurin inhibitor (pimecrolius or tacrolimus).

Approval Duration

All Lines of Business (except Medicare): 12 months

II. Continued Therapy Approval

A. All Indications in Section I (must meet all):

1. Member is currently receiving medication that has been authorized by RxAdvance or the member has met been initial approval criteria.

Approval Duration

This clinical policy has been developed to authorize, modify, or determine coverage for individuals with similar conditions. Specific care and treatment may vary depending on individual need and benefits covered by the plan. This policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. This document may contain prescription brand name drugs that are trademarks of pharmaceutical manufacturers that are not affiliated with RxAdvance.

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All Lines of Business (except Medicare): 12 months

References

1. Atopic dermatitis (eczema) guidelines: 2023 American Academy of Allergy, Asthma and Immunology/American College of Allergy, Asthma and Immunology Joint Task Force on Practice Parameters GRADE– and Institute of Medicine–based recommendations. Chu, Derek K. et al. Annals of Allergy, Asthma & Immunology, Volume 132, Issue 3, 274 – 312. Available at: https://www.annallergy.org/article/S1081-1206(23)01455-2/fulltext. Accessed February 17, 2025. Joint AAD–NPF
2. Guidelines of care for the management and treatment of psoriasis with topical therapy and alternative medicine modalities for psoriasis severity measures. Elmets, Craig A. et al. Journal of the American Academy of Dermatology, Volume 84, Issue 2, 432 – 470. Available at: https://www.jaad.orf/article/S0190-9622(20)32288-X/fulltext. Accessed February 17, 2025.
3. An Up-to-Date Approach to the Management of Seborrheic Dermatitis - JDDonline - Journal of Drugs in Dermatology. JDDonline - Journal of Drugs in Dermatology. Published 2022. Accessed March 7, 2025. Available at: https://jddonline.com/articles/an-up-to-date-approach-to-the-management-of-seborrheic-dermatitis-S1545961622P1373X/. Accessed March 7, 2025.

Review/Revision History	Review/Revision Date	P&T Approval Date
Policy established.	09/12/2022	10/19/2022
Policy was reviewed.	11/27/2023	11/27/2023
Policy was reviewed. 1. Added "Member is currently receiving or has been treated with this medication within the past 90 days, excluding manufacturer samples" to reauth.	3/1/2024	2/28/2024
Policy Reviewed: Removed: 1. Criteria for CS potency 2. BSA criteria Merged with Vtama policy 771	4/1/2024	4/1/2024
Policy Reviewed: 1. Indication added (atopic dermatitis). 2. Removed prescriber requirement. 3. Updated continuation of therapy language.	2/13/2025	
Policy Reviewed: 1. Zoryve foam added. 2. Sebhorrheic dermatitis indication added.	3/7/2025	

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Policy Reviewed: 1. Zoryve foam now approved for plaque psoriasis 2. Added Zoryve 0.15% cream to policy	6/19/2025	6/19/2025
Policy was reviewed	08/19/2026	N/A

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