

**Pharmacy Medical Necessity Policy**

**Immune Suppressants – Topical – Unified Formulary**

**Policy Number:** 9.139

**Version Number:** 2.1

**Version Effective Date:** 1/1/2022

<p><b>Product Applicability</b>   <input type="checkbox"/> <b>All Plan<sup>+</sup> Products</b></p>	
<p><b>Well Sense Health Plan</b></p> <p><input type="checkbox"/> New Hampshire Medicaid</p>	<p><b>Boston Medical Center HealthNet Plan</b></p> <p><input checked="" type="checkbox"/> MassHealth - MCO</p> <p><input checked="" type="checkbox"/> MassHealth - ACO</p> <p><input type="checkbox"/> Qualified Health Plans/ConnectorCare/Employer Choice Direct</p> <p><input type="checkbox"/> Senior Care Options</p>
<p><b>Benefit</b></p>	<p><input checked="" type="checkbox"/> Pharmacy Benefit</p> <p><input type="checkbox"/> Medical Benefit</p>

Note: Disclaimer and audit information is located at the end of this document.

**Prior Authorization Policy**

**Reference Table:**

Drugs that require PA	No PA
Eucrisa® (crisaborole) <sup>PD</sup>	Elidel® (pimecrolimus) §
	Protopic® (tacrolimus topical) §

<sup>PD</sup> Preferred Drug. In general, a trial of the preferred drug or clinical rationale for prescribing a non-preferred drug within a therapeutic class is required. Please note, for Immune Suppressants – Topical agents, a trial with a preferred agent is not required prior to approval of a non-preferred agent.

§ Brand Preferred over generic equivalents. In general, a trial of the preferred drug or clinical rationale for prescribing the non-preferred drug generic equivalent is required.

<sup>+</sup> Plan refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name Well Sense Health Plan.

**Approval Criteria:**

<b>Eucrisa<sup>®</sup></b> (crisaborole)	<ol style="list-style-type: none"> <li>1. Member has a diagnosis of atopic dermatitis; <b>AND</b></li> <li>2. Member is 3 months of age or older; <b>AND</b></li> <li>3. Member has documentation of <b>ONE</b> of the following: <ol style="list-style-type: none"> <li>a. Inadequate response or adverse reaction to one topical corticosteroid or topical calcineurin inhibitor (e.g. pimecrolimus or tacrolimus); <b>OR</b></li> <li>b. Contraindication to both topical corticosteroids and topical calcineurin inhibitors</li> </ol> </li> </ol>
<b>Duration of Initial Authorization:</b>	Prior authorization may be issued for up to <b>3 months</b> .
<b>Recertification Criteria:</b>	<ol style="list-style-type: none"> <li>1. Member has a diagnosis of atopic dermatitis; <b>AND</b></li> <li>2. Member is 3 months of age or older; <b>AND</b></li> <li>3. Member has experienced a positive response to therapy</li> </ol>
<b>Duration of Recertification Authorization:</b>	Prior authorization may be issued for up to <b>1 year</b> .

**Clinical Background Information and References**

1. Eucrisa™[package insert] Palo Alto, CA; Anacor Pharmaceuticals, Inc. December 2016.
2. Prescribing Information. Protopic® Ointment, tacrolimus. Astellas Pharma US, Inc. Grand Island, NY 14072. May 2012.
3. Prescribing Information. Elidel® Cream, pimecrolimus. Novartis Pharmaceuticals Corp., East Hanover, NJ 07936. March 2014.

<b>Original Approval Date</b>	<b>Original Effective Date</b>	<b>Policy Owner</b>	<b>Approved by</b>
12/1/2020	1/1/2021	Pharmacy Services	Pharmacy & Therapeutics (P&T) Committee

**Policy Revisions History**

<sup>†</sup> Plan refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name Well Sense Health Plan.

<b>Policy Revisions History</b>			
<b>Review Date</b>	<b>Summary of Revisions</b>	<b>Revision Effective Date</b>	<b>Approved by</b>
12/1/2020	9.027 Topical Immunomodulators Policy retired; new policy created for Eucrisa and generic tacrolimus ointment and pimecrolimus cream to align with MH Unified Formulary Policy	1/1/2021	P&T Committee
8/12/2021	P&T Annual Review. No changes.	12/1/2021	P&T Committee
10/1/2021	Minor criteria language updates	1/1/2022	P&T Committee

### **Next Review Date**

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8/2022

### **Other Applicable Policies**

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### **Disclaimer Information**

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Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits

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on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

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