

Pharmacy Policy

Topical Corticosteroids

Policy Number: 9.906

Version Number: 2.0

Version Effective Date: 3/1/2022

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

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

Prior Authorization Policy

Products Affected:

Amcinonide 0.1% cream/ointment/lotion	fluocinolone 0.01% solution/oil (body and scalp)
Betamethasone dipropionate 0.05% ointment	fluocinonide 0.05% gel/ointment/solution
Betamethasone valerate foam 0.12%	fluocinonide 0.1% cream
Clobetasol (all formulations)	flurandrenolide 0.05% lotion/cream/ointment
Capex shampoo 0.01%	fluticasone 0.05% lotion
clocortolone 0.1% cream	hydrocortisone valerate 0.2% ointment/cream
desonide 0.05% lotion/cream	halobetasol 0.05% ointment
diflorasone 0.05% cream/ointment/solution	hydrocortisone butyrate 0.1% solution/ointment/cream/lotion
desoximetasone 0.25% ointment/cream, 0.05% ointment/cream/gel	Halog 0.1% ointment
	triamcinolone 0.025% lotion
	Prednicarbate 0.1% cream

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The Plan may authorize coverage of the above products for members meeting the following criteria:

Covered Use	All FDA approved indications not otherwise excluded
Exclusion Criteria	None
Required Medical Information	<ol style="list-style-type: none"> 1. An inadequate response, allergy, or intolerance to a trial of at least two covered topical corticosteroids of the same potency (see appendix A); OR 2. If the request is for a shampoo, solution, scalp oil, or foam, the medication will be used to treat a condition of the scalp; AND <ol style="list-style-type: none"> a. An inadequate response, allergy, or intolerance to a trial of a covered corticosteroids shampoo, solution, scalp oil, or foam of the same potency if there is one (see appendix A)
Coverage Duration	12 months
Other criteria	<p>Reauthorization criteria:</p> <ol style="list-style-type: none"> 1. Prescriber attestation that the patient’s clinical condition has improved or stabilized with the current therapy with no significant adverse events.

Appendix A

Low Potency Topical Corticosteroids	
Covered	PA Required
Alclometasone 0.05% cream/ointment Hydrocortisone 2.5% ointment/lotion/ cream Fluocinolone 0.01% cream Desonide 0.05% ointment	Desonide 0.05% cream/lotion Fluocinolone 0.01% solution/oil

Medium Potency Topical Corticosteroids	
Covered	PA Required
Betamethasone valerate 0.1% cream/ lotion Betamethasone dipropionate 0.05% lotion Fluocinolone 0.025% ointment/cream Fluticasone 0.005% ointment Fluticasone 0.05% cream Mometasone 0.1% solution/ointment/ cream Triamcinolone 0.1% ointment/cream/ lotion Triamcinolone 0.025% ointment/cream	Betamethasone valerate 0.12% foam Flurandrenolide 0.05% cream/lotion/ Ointment Capex shampoo 0.01% Clocortolone 0.1% cream Desoximetasone 0.05% cream/ointment Diflorasone 0.05% cream/ointment/ Fluticasone 0.05% lotion

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 Topical Corticosteroids

Prednicarbate 0.1% ointment	Hydrocortisone Butyrate 0.1% cream/ ointment/solution/lotion Hydrocortisone Valerate 0.2% ointment/ cream Triamcinolone 0.025% lotion Prednicarbate 0.1% cream
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High Potency Topical Corticosteroids	
Covered	PA Required
Betamethasone dipropionate 0.05% cream Betamethasone dipropionate aug 0.05% cream/lotion Betamethasone valerate 0.1% ointment Triamcinolone 0.5% ointment Fluocinonide 0.05% cream	Amcinonide 0.1% cream/ointment/lotion Betamethasone dipropionate 0.05% ointment Desoximetasone 0.05% gel Diflorasone 0.05% cream fluocinonide 0.05% gel/ointment/ solution fluocinonide 0.1% cream

Very High Potency Topical Corticosteroids	
Covered	PA Required
Betamethasone dipropionate aug 0.05% ointment/gel Halobetasol 0.05% cream	Clobetasol 0.05% cream/ointment/gel/ solution/lotion/shampoo/liquid Clobetasol E 0.05% cream Desoximetasone 0.25% cream/ointment Halobetasol 0.05% ointment Halog 0.1% ointment Halcinonide 0.1% cream

Clinical Background Information and References

1. Bactroban nasal ointment (mupirocin) [prescribing information]. Research Triangle Park, NC: GlaxoSmithKline; May 2017.
2. Harris, Anthony. "Methicillin-resistant Staphylococcus aureus (MRSA) in adults: Prevention and control." UpToDate. Last updated Jul 31,2018. Accessed on Oct 25, 2018.
3. Weston LW, Howe W. Treatment of atopic dermatitis (eczema). Available at UpToDate. Last updated Mar 12, 2019. Accessed April 2019.
4. Fazio SB, Yosipovitch G. Pruritus: Overview of management. Available at UpToDate. Last updated Jan 15, 2019. Accessed April 2019.

Original Approval Date	Original Effective Date	Policy Owner	Approved by
9/10/2020	1/1/2021	Pharmacy Services	Pharmacy & Therapeutics (P&T) Committee

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Policy Revisions History

Review Date	Summary of Revisions	Revision Effective Date	Approved by
9/10/2020	P&T Annual Review: Policy 9.111 Topical Medications (Misc) Policy retired, new policy created for topical corticosteroids for QHP. Added amcinonide (other formulations), clobetasol (other formulations), fluocinolone 0.01% sol, betamethasone valerate foam 0.12%, betamethasone dipropionate 0.05% oint, hydrocortisone valerate 0.25 oint, triamcinolone 0.025% lot, clocortolone 0.1% cream, fluocinonide 0.05% gel, halobetasol 0.05% oint, diflorasone 0.05% cream, desoximetasone 0.025% oint/cream, 0.05% oint/cream/gel, flurandrenolide 0.05% lot/cream, hydrocortisone butyrate 0.1% sol/ointment/cream, fluticasone 0.05% lot, desonide 0.05% oint/lot/cream, Capex shampoo, Cordan, Prednicarbate 0.1% cream to PA; added doxepin cream to covered; moved Zonalon and Prudoxin to non preferred; removed Bactroban nasal ointment due to product discontinuation; made reauthorization criteria applicable to topical corticosteroids; added reauth duration of 12 months	1/1/2021	P&T Committee
1/4/2021	Added fluocinonide 0.1% cream to PA required High Potency field due to previous omission	1/4/2021	P&T Committee
2/3/2021	Products affected list expanded to include additional formulations: fluocinolone 0.01% oil, fluocinonide 0.05% ointment/solution, flurandrenolide 0.05% ointment, hydrocortisone valerate 0.2% cream, hydrocortisone butyrate 0.1% lotion. Added Diflorasone 0.05% cream/ointment and Halcinonide 0.1% cream to policy.	2/3/2021	P&T Committee

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Policy Revisions History

	Changed language in Required Medical Information section from 'comparable' to 'the same'		
11/11/2021	P&T Annual Review. Add different criteria for solution, foam, scalp oil, or shampoo. Removed diflorasone solution (no such product) and Cordan (non-formulary). Re-formatted drug tables (no change in intent).	3/1/2022	P&T Committee

Next Review Date

11/2022

Reference to Applicable Laws and Regulations, If Any

Disclaimer Information

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 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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