

Pharmacy Policy

Step Therapy Policy - Topical Steroids

Policy Number: 9.918

Version Number: 2.0

Version Effective Date: 3/1/2022

Product Applicability <input type="checkbox"/> All Plan+ Products	
Well Sense Health Plan	Boston Medical Center Healthnet Plan
<input type="checkbox"/> New Hampshire Medicaid	<input checked="" type="checkbox"/> Masshealth - MCO
	<input checked="" type="checkbox"/> Masshealth - ACO
	<input type="checkbox"/> Qualified Health Plans
	<input type="checkbox"/> Senior Care Options

Note: Disclaimer And Audit Information Is Located At The End Of This Document.

Prior Authorization Policy

POLICY STATEMENT:

A step therapy program has been developed to encourage the use of generic Step-1 products prior to the use of a Step-2 or Step--3 product, without interrupting existing therapy. If the step therapy rule is not met for a Step-2 or Step-3 agent at the point of service, coverage will be determined by the step therapy criteria below. All approvals are provided for 1 year in duration.

Standard Criteria:

The plan may authorize coverage of the products in the appendix A for all FDA approved indications not otherwise excluded and for members meeting the following criteria when step therapy is not met at point of sale from claims history:

1. Prescribers must provide documentation (including trial dates and outcome) that the member has tried and failed the appropriate number of applicable step agents as indicated in Appendix A and in the coverage criteria requirements; **OR**

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2. Prescribers must provide documentation that the member has a contraindication to, or other clinical rationale preventing the use of, **ALL** applicable step agents indicated in Appendix A.

Appendix A: Step Therapy Details

Topical Steroids I		
Step 1	Step 2	Coverage Criteria
Alclometasone (Aclovate®) 0.05% cream, ointment Augmented betamethasone 0.05% ointment, lotion, gel Augmented betamethasone dipropionate (Diprolene AF®) 0.05% cream Betamethasone valerate 0.1% lotion Clobetasol Propionate Emollient Base Cream 0.05% Clobetasol Propionate 0.05% gel Clobetasol Propionate 0.05% solution Clobetasol Propionate 0.05% ointment Clobetasol Propionate 0.05% cream Halobetasol propionate (Ultravate®) 0.05% cream, ointment Diflorasone diacetate 0.05% cream Desoximetasone (Topicort®) 0.05% ointment, cream, gel; 0.25% cream, ointment Fluocinolone 0.01% (Derma-Smoothe®) oil Fluocinolone (Synalar®) 0.01% solution Hydrocortisone 0.5%, 1%, 2.5% cream; 1%, 2.5% lotion; 0.5%, 1%, 2.5% ointment Hydrocortisone acetate 1% cream; 1% ointment Mometasone furoate 0.1% ointment Triamcinolone acetonide 0.5% cream, ointment	Desonide Oint 0.05% Desonide Lotion 0.05% Desonide Cream 0.05%	Pharmacy Claims Indicating The Use of A Step 1 Agent In The Previous 130 Days

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Top Steroids II

Step 1	Step 2	Coverage Criteria
1 Clobetasol Propionate Emollient C 0.05% Clobetasol Propionate Gel 0.05% Clobetasol Propionate S 0.05% Clobetasol Propionate O 0.05% Clobetasol Propionate C 0.05% Halobetasol propionate 0.05% C, O	Clobetasol Propionate Foam 0.05 % Clobetasol Propionate Spray 0.05% Clobetasol Propionate Shampoo 0.05% Clobetasol Propionate Lotion 0.05%	Pharmacy Claims Indicating The Use of A Step 1 Agent In The Previous 130 Days

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

Policy Revisions History

Review Date	Summary Of Revisions	Revision Effective Date	Approved By
12/1/2020	Created separate policies per applicable line of business. Coverage duration changed to 1 year. Addition of policy statement and standard criteria. Changed trial look ball to 130 days from 120 days.	1/1/2021	P&T Committee
11/11/2022	P&T Annual Review. Update to standard ST language. Replaced abbreviations for cream, ointment, gel, etc. with full words.	3/1/2022	P&T Committee

Next Review Date

11/2022

Other Applicable Policies

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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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