BOSTON MEDICAL CENTER HEALTHNet PLAN

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Pharmacy Policy

Topical Medications (Misc)

Policy Number: 9.906
Version Number: 2.0
Version Effective Date: 3/1/2022

Product Applicability	☐ **All Plan+ Products**
Well Sense Health Plan ☐ New Hampshire Medicaid	**Boston Medical Center HealthNet Plan** ☒ MassHealth - MCO ☒ MassHealth - ACO ☐ Qualified Health Plans/ConnectorCare/Employer Choice Direct ☐ Senior Care Options

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

Prior Authorization Policy

Products Affected:

- doxepin 5% cream
- mupirocin 2% cream

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

Covered Use	All FDA approved indications not otherwise excluded
Required Medical Information	**doxepin 5% cream** 1. Diagnosis of pruritus with atopic dermatitis or pruritus with lichen simplex chronicus; ***AND*** 2. Inadequate response or intolerance to two of the following: a. systemic therapy (eg. antihistamines, oral corticosteroids)

+ *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. topical corticosteroid c. topical calcineurin inhibitors **mupirocin 2% cream** 1. Documentation of an allergy to an inactive ingredient in mupirocin ointment that is not found in mupirocin cream; ***OR*** 2. Documentation of clinical rationale why mupirocin cream is medically necessary over mupirocin ointment
Age Restrictions	**doxepin 5% cream:** 18 years of age and older
Coverage Duration	**doxepin 5% cream:** 1 tube (45 grams) per year **mupirocin 2% cream:** 1 year

Clinical Background Information and References

1. Doxepin cream [package insert]. Mylan Pharmaceuticals Inc.; Morgantown, WV. May 2017
2. Howe W. Treatment of atopic dermatitis (eczema). Available at UpToDate. Last updated November 10, 2021. Accessed November 2021.
3. Fazio SB, Yosipovitch G. Pruritus: Therapies for localized pruritis. Available at UpToDate. Last updated July 7, 2021. Accessed November 2021.
4. Mupirocin cream [package insert]. Encube Ethicals, Inc.; Durham, NC. August 2021

Original Approval Date	Original Effective Date	Policy Owner	Approved by
11/08/2018	03/04/2019	Pharmacy Services	Pharmacy & Therapeutics (P&T) Committee

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date**	**Approved by**
09/10/2020	P&T Annual Review: Policy 9.111 Topical Medications (Misc) Policy retired, new	1/1/2021	P&T Committee

Policy Revisions History			
	policy created. Moved Amcinonide cream 0.1%, Diflorasone Ointment 0.05% and Cortisporin cream to non-preferred; removed Bactroban nasal ointment due to product discontinuation; removed clobetasol shampoo from policy as it is already on step therapy		
2/18/2021	P&T Review: Added criteria to prefer Mupirocin ointment before coverage of cream	6/1/2021	P&T Committee
11/11/2021	P&T Annual Review. Remove Prudoxin and Zonalon from policy (make non-formulary). Add documentation requirements to mupirocin cream. Remove reauthorization criteria.	3/1/2022	P&T Committee

Next Review Date

11/2022

Other Applicable Policies

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.