Pharmacy Medical Necessity Guidelines: Topical Corticosteroids

Effective: July 1, 2020

Prior Authorization Required	√	Type of Review – Care Management	
Not Covered		Type of Review – Clinical Review	√
Pharmacy (RX) or Medical (MED) Benefit	RX	Department to Review	RXUM

These pharmacy medical necessity guidelines apply to the following:

Commercial Products

☒ Tufts Health Plan Commercial products – large group plans
☒ Tufts Health Plan Commercial products – small group and individual plans
☒ Tufts Health Freedom Plan products – large group plans
☒ Tufts Health Freedom Plan products – small group plans
- CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

Tufts Health Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product)
☐ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans
☐ Tufts Health RITogether – A Rhode Island Medicaid Plan

Fax Numbers:

RXUM: 617.673.0988

Note: This guideline does not apply to Medicare Members (includes dual eligible Members).

OVERVIEW

FOOD AND DRUG ADMINISTRATION-APPROVED INDICATIONS

Topical corticosteroids are commonly used for the treatment of skin disorders. They work by inducing an inflammatory response in the skin through several mechanisms.

In the tables below, branded products of preferred topical corticosteroids require prior authorization. For non-preferred topical corticosteroids, both generic and brand products require prior authorization.

Preferred Topical Corticosteroids

Low Potency	Medium Potency	High Potency	Very High Potency
alclometasone 0.05% cream, ointment	betamethasone dipropinoate 0.05% lotion	betamethasone dipropinoate augmented 0.05% cream	betamethasone dipropionate augmented 0.05% gel, lotion, ointment
betamethasone valerate 0.1% lotion	betamethasone valerate 0.1% cream	betamethasone dipropionate 0.05% cream	halobetasol 0.05% cream
desonide 0.05% ointment	fluocinolone 0.025% cream, ointment	betamethasone valerate 0.1% ointment	
fluocinolone 0.01% cream	fluticasone 0.05% cream	fluocinonide 0.05% cream, cream (emulsified)	
hydrocortisone 0.5% cream, ointment; 1% and 2.5% cream, lotion, ointment	mometasone 0.1% cream, solution (lotion)	fluticasone 0.005% ointment	
	prednicarbate 0.1% ointment	mometasone 0.1% ointment	
	triamcinolone 0.025% and 0.1% cream, lotion, ointment	triamcinolone 0.5% cream, ointment	

Non-Preferred Topical Corticosteroids

Low Potency	Medium Potency	High Potency	Very High Potency
desonide 0.05% cream, lotion,	clocortolone 0.1% cream	amcinonide 0.01% cream, lotion, ointment	clobetasol 0.05% cream, cream (emollient), foam, foam (emulsion), gel, lotion, ointment, shampoo, solution, spray
fluocinolone 0.01% oil (body and scalp), shampoo, solution	desoximetasone 0.05% cream, ointment	betamethasone dipropinoate 0.05% ointment	fluocinonide 0.1% cream
hydrocortisone 2.5% solution	flurandrenolide 0.05% cream, lotion, ointment; flurandrenolide tape	betamethasone valerate 0.12% foam	halobetasol 0.05%ointment
	fluticasone 0.05% lotion	desoximetasone 0.05% gel; 0.25% cream, ointment	
	hydrocortisone butyrate 0.1% cream, lotion, lipo base cream, ointment, solution	diflorasone 0.05% cream, ointment	
	hydrocortisone probutate 0.1% cream	fluocinonide 0.05% gel, ointment, solution	
	hydrocortisone valerate 0.2% cream, ointment	halcinonide 0.1% cream, ointment	
	prednicarbate 0.1% cream		
	triamcinolone 0.05% ointment, 0.147 mg/g spray		

COVERAGE GUIDELINES

The plan may authorize coverage of a **non-preferred topical corticosteroid** medication for Members when the following criterion is met:

1. The Member had an insufficient response to at least two preferred topical corticosteroid agents of the same potency*

*If a request is for a **non-preferred topical corticosteroid** of very high potency, a trial with a minimum of one preferred high potency and one preferred very high potency topical corticosteroid is required.

The plan may authorize coverage of **non-preferred topical corticosteroid solutions and foams** (e.g. clobetasol solution) when the following criteria are met:

1. The member has a documented diagnosis of conditions affecting the scalp

LIMITATIONS

None

CODES

None

REFERENCES

1. UpToDate [database on the Internet]. Wolters Kluwer. Updated periodically. uptodate.com [available with subscription]. Accessed 2017 January 31.
2. Micromedex Solutions [database online]. Greenwood Village, CO: Truven Health Analytics Inc. Updated periodically. micromedexsolutions.com [available with subscription]. Accessed 2017 January 31.

APPROVAL HISTORY

February 14, 2017: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:

- November 14, 2017: Added criteria for approval of topical corticosteroid solutions.
- December 11, 2018: Administrative update to the template.
- March 12, 2019: Updated criteria to require trial and failure with at least two preferred topical corticosteroid agents of the same potency.
- April 14, 2020: Effective July 2020, moved desonide 0.05% ointment, and halobetasol 0.05% cream to preferred, and moved hydrocortisone butyrate 0.1% ointment to non-preferred.

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.