TUFTS Health Plan

Pharmacy Medical Necessity Guidelines: Corticosteroid Medications, Topical

Effective: October 13, 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

FDA-APPROVED INDICATIONS

Topical corticosteroid agents are indicated for steroid-responsive dermatose such as contact dermatitis, atopic dermatitis, nummular eczema, stasis eczema, asteatotic eczema, lichen planus, lichen simplex chronicus, insect and arthropod bite reactions, first- and second-degree localized burns and sunburns.

	Low Potency	Medium Potency	High Potency	Very High Potency
Preferred Products	Alclometasone 0.05% cream, ointment	Betamethasone Valerate 0.1% cream	Betamethasone Dipropionate 0.05% cream, ointment	Betamethasone Dip. Augmented 0.05% ointment, gel
	Fluocinolone 0.01% cream	Betamethasone Dipropionate 0.05% lotion	Betamethasone Dip., Augmented 0.05% cream	
	Hydrocortisone 0.5%, 1%, 2.5% cream, ointment, lotion, soln	Fluocinolone 0.025% cream, ointment	Betamethasone Valerate 0.1% ointment	
		Fluticasone 0.05% cream, lotion, 0.005% ointment	Desoximetasone 0.25% cream, ointment	
		Hydrocortisone Valerate 0.2% cream	Fluocinonide 0.05% cream, ointment, gel, soln	
		Mometasone 0.1% cream, ointment, solution	Triamcinolone 0.5% cream, ointment	
		Triamcinolone 0.025%, 0.1% cream, ointment, lotion		

Non-Preferred Products	Desonide 0.05% cream, lotion, ointment	Flurandrenolide 0.025%, 0.05% cream, oint; 4 mcg/cm^2 tape	Amcinonide 0.01% cream, ointment, lotion	Clobetasol 0.05% cream, ointment, gel, soln
		Clocortolone 0.1% cream	Desoximetasone 0.05% Gel	Diflorasone 0.05% ointment
		Desoximetasone 0.05% cream, ointment	Diflorasone 0.05% cream	Fluocinonide 0.1% cream
		Hydrocortisone Butyrate cream, ointment, solution	Halcinonide 0.1% cream, ointment	Halobetasol 0.05% cream, ointment, foam
		Hydrocortisone Valerate 0.2% ointment	Halobetasol 0.01% lotion	

COVERAGE GUIDELINES

The plan may authorize coverage of a topical corticosteroid medication for Members when the following criterion is met and limitations do not apply:

1. The Member had an insufficient response to at least two preferred topical corticosteroid agents of comparable potency, or most similar potency*

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

The Plan may authorization 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

1. Quantities may be limited to single package size, e.g. one tube per Rx.
2. Requests for brand-name products, which have AB-rated generics, will be reviewed according to Brand Name criteria.

CODES

None

REFERENCES

1. Lexicomp Online: Topical Corticosteroids. Available from: online.lexi.com/lco/action/doc/retrieve/docid/patch_f/3674386, accessed 11/19/14
2. Facts & Comparisons: Corticosteroids, Topical. Available from: online.factsandcomparisons.com/MonoDisp.aspx?monoid=fandc-hcp10556&book=DFC, accessed 11/19/14.
3. Cordran (flurandrenolide) [prescribing information]. San Antonio, TX: DPT Laboratories; May 2017.
4. Clobex lotion (clobetasol) [prescribing information]. Fort Worth, TX: Galderma Laboratories; February 2018.
5. Cormax solution (clobetasol) [prescribing information]. Fairfield, NJ: Medimetriks Pharmaceuticals; April 2014.
6. Bryhali lotion (halobetasol) [prescribing information]. Bridgewater, NJ: Bausch Health US, LLC; June 2020.
7. Lexette foam (halobetasol) [prescribing information]. Greenville, NC: Mayne Pharma; May 2020.

APPROVAL HISTORY

December 9, 2014: Reviewed by Pharmacy & Therapeutics Committee. Adapted table to reflect preferred products; added the trial with the preferred product should be of comparable strength.

Subsequent endorsement date(s) and changes made:

1. November 10, 2015: Approval duration modified to life of plan.
2. January 1, 2016: Administrative change to rebranded template.
3. November 15, 2016: Removed "requests for quantities that exceed the quantity limit will be reviewed according to the Drugs with Quantity Limitations criteria" from the limitations section.

4. May 9, 2017: Administrative update. Effective 6/1/2017, Medical Necessity Guideline applies to Tufts Health RITogether.
5. December 12, 2017: No changes.
6. December 11, 2018: Updated list of preferred medium potency steroids to include fluticasone 0.05% lotion and 0.005% ointment. Administrative changes made to template.
7. February 12, 2019: Added Bryhali lotion (halobetasol 0.01%) to the Medical Necessity Guideline.
8. December 10, 2019: Added Lexette foam (halobetasol 0.05%) to the Medical Necessity Guideline. Also added that non-preferred foams and solutions will be approved if the member has a condition affecting the scalp.
9. October 13, 2020: No changes.

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.