# Pharmacy Medical Necessity Guidelines: Eucrisa® (crisaborole)

*Effective: January 1, 2021*

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|---|---|---|---|
| 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 ADMNISTRATION-APPROVED INDICATIONS**

Eucrisa (crisaborole) is a phosphodieterase-4 (PDE-4) inhibitor indicated for the topical treatment of mild to moderate atopic dermatitis in adult and pediatric patients 3 months of age and older.

Eucrisa (crisaborole) would provide an alternative to topical corticosteroids and topical calcineurin inhibitors in patients with mild to moderate disease.

## COVERAGE GUIDELINES

The plan may authorize coverage for Eucrisa (crisaborole) for Members when the following criteria are met:

1. Documented diagnosis of atopic dermatitis

**AND**

2. Members is at least 3 months of age or older

**AND**

3. Documentation of one of the following:
   a. Inadequate response or adverse reaction to one topical corticosteroid or topical calcineurin inhibitor

   **OR**

   b. Contraindication to both topical corticosteroids and topical calcineurin inhibitors

## LIMITATIONS

1. Coverage of Eucrisa is limited to 60 grams per 30 days.

## CODES

None

## REFERENCES


1. Eucrisa (crisaborole) [prescribing information]. New York, NY: Pfizer Labs; April 2020.
2. Ference JD, Last AR. Choosing topical corticosteroids. *Am Fam Physician*. 2009; 79(2):135-40.
3. Frankel HC, Qureshi AA. Comparative effectiveness of topical calcineurin inhibitors in adult patients with atopic dermatitis. *Am J Clin Dermatol*. 2012; 13(2):113-23
4. Garside R, Stein K, Castelnuovo E et al. The effectiveness and cost-effectiveness of pimecrolimus and tacrolimus for atopic eczema: a systematic review and economic evaluation. *Health Technol Assess*. 2005; 9(29): iii, xi-iii, 230.
5. Hanifin JM, Paller AS, Eichenfield L et al. Efficacy and safety of tacrolimus ointment treatment for up to 4 years in patients with atopic dermatitis. J Am Acad Dermatol. 2005; 53(2 Suppl 2):S186-S194.

6. Paller AS, Tom WL, Lebwohl MG et al. Efficacy and safety of crisaborole ointment, a novel, nonsteroidal phosphodiesterase 4 (PDE4) inhibitor for the topical treatment of atopic dermatitis (AD) in children and adults. J Am Acad Dermatol. 2016; 75(3):494-503.e4.

## APPROVAL HISTORY

April 28, 2020: Reviewed by Pharmacy & Therapeutics Committee.

1. November 24, 2020: Effective 1/1/21, updated MNG to reflect new quantity limit.

## 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.