Pharmacy Medical Necessity Guidelines: Eucrisa (crisaborole)

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

Eucrisa (crisaborole) is a Food and Drug Administration (FDA)-approved 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 (TCS) and topical calcineurin inhibitors (TCI) 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:

For members 3 months to 2 years of age

1. Documented diagnosis of mild to moderate atopic dermatitis
2. Inadequate treatment response, intolerance, or contraindication to the following:
    a. Low potency topical corticosteroid

For members 2 years to 17 years of age

1. Documented diagnosis of mild to moderate atopic dermatitis
2. Inadequate treatment response, intolerance, or contraindication to ALL of the following:
    a. Low potency topical corticosteroid
    b. Topical calcineurin inhibitor (i.e. tacrolimus, pimecrolimus)

For members ≥ 18 years of age

1. Documented diagnosis of mild to moderate atopic dermatitis
2. Inadequate treatment response, intolerance, or contraindication to ALL of the following:
    a. Medium potency topical corticosteroid
    b. b. Topical calcineurin inhibitor (i.e. tacrolimus, pimecrolimus)

LIMITATIONS

- For a list of preferred topical corticosteroids see the Topical Corticosteroids MNG for each respective line of business.

CODES

None

REFERENCES

1. Eucrisa prescribing information. New York, NY: Pfizer Labs; 2020 March.
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

June 13, 2017: Reviewed by Pharmacy & Therapeutics Committee.
Subsequent endorsement date(s) and changes made:

1. June 12, 2018: No changes
2. June 11, 2019: Administrative update to template.
3. April 14, 2020: Effective July 1, 2020 updated indication in overview and added coverage criteria for members 3 months to 2 years of age. Updated coverage criteria for members age 18 and older to require trial and failure, intolerance, or contraindication to medium potency topical corticosteroids (from high potency). Added the limitation referencing preferred topical corticosteroids listed in each business line's respective topical corticosteroid MNG.
4. April 28, 2020: Effective May 1, 2020, Tufts Health Together is removed from Medical Necessity Guideline.

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.