Pharmacy Medical Necessity Guidelines: Immunomodulators, Topical

Effective: January 1, 2021

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

Imiquimod is indicated for:

- Actinic keratosis (all strengths): For the topical treatment of clinically typical, nonhyperkeratotic, nonhypertrophic, visible or palpable actinic keratoses on the full face or balding scalp in immunocompetent adults.
- Genital and perianal warts (3.75% and 5% cream only): For the treatment of external genital and perianal warts (condyloma acuminata) in patients 12 years and older.
- Superficial basal cell carcinoma (5% cream only): For the topical treatment of biopsy-confirmed, primary superficial basal cell carcinoma in immunocompetent adults with a maximum tumor diameter of 2 cm located on the trunk (excluding anogenital skin), neck, or extremities (excluding hands and feet), when surgical methods are medically less appropriate and patient follow-up can be reasonably ensured

For actinic keratosis, imiquimod (Zyclara®) 2.5% and 3.75% treatment consists of up to 2 packets or pumps per day for two 14-day cycles separated by a 14-day rest period with no treatment; dosing should not to exceed 56 packets or pumps per complete course of treatment (two 14-day cycles).

Ingenol gel is an inducer of cell death indicated for the topical treatment of actinic keratosis. For the treatment of actinic keratosis on the face of scalp, ingenol 0.015% gel should be applied to the affected area. For the treatment of actinic keratosis on the trunk or extremities, ingenol 0.05% gel should be applied to the affected area.

Fluorouracil 5% cream, imiquimod 5% cream and diclofenac 3% gel (Solaraze) are preferred products and are covered without prior authorization. Diclofenac 3% gel is approved for the topical treatment of actinic keratosis. Fluorouracil 0.5% cream is approved for the topical treatment of multiple actinic or solar keratoses of the face and anterior scalp. Fluorouracil 5% cream is approved for the treatment of multiple actinic or solar keratoses as well as the treatment of superficial basal cell carcinoma.

Medication	Preferred Drug List Status	Quantity Limit
Diclofenac 3% gel (generic Solaraze)	Covered	100gm per Rx; 90 days per year
Fluorouracil 0.5%, 5% cream (generic Carac, Efudex)	Covered	n/a
Fluorouracil 2%, 5% solution	Covered	n/a

Medication	Preferred Drug List Status	Quantity Limit
Imiquimod 5% cream (generic Aldara)	Covered	n/a
Imiquimod 2.5% and 3.75% (Zyclara)	PA	Two pumps or packets per day for up to two 14 day cycles
Ingenol 0.015%, 0.05% (Picato)	PA	One box per single treatment course

COVERAGE GUIDELINES

The plan may authorize coverage of topical immunomodulators for Members when the following criteria for a particular regimen are met and limitations do not apply:

Imiquimod 2.5% (Zyclara)

1. The Member has a diagnosis of actinic keratosis and had an insufficient response to therapy, or the provider indicated clinical inappropriateness of therapy with the preferred products, imiquimod 5% and fluorouracil

Imiquimod 3.75%

1. The Member has a diagnosis of actinic keratosis and had an insufficient response to therapy, or the provider indicated clinical inappropriateness of therapy with the preferred products, imiquimod 5% and fluorouracil

OR

2. The Member has a diagnosis of external genital warts or perianal warts and had an insufficient response to therapy, or the provider indicated clinical inappropriateness of therapy with the preferred product, imiquimod 5%

Ingenol (Picato)

1. The Member had an insufficient response to therapy or the provider indicated clinical inappropriateness of therapy with fluorouracil

	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/Solution	**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/ Solution**	
		Mometasone 0.1% Cream/Ointment/ Solution	**Triamcinolone 0.5% Cream/Ointment**	
		Triamcinolone 0.025%, 0.1% Cream/Ointment/ Lotion		
Non-	Desonide 0.05% Cream/Lotion/ Ointment	Flurandrenolide 0.025%, 0.05% Cream/Ointment;	Amcinonide 0.01% Cream/Lotion/Ointment	Clobetasol 0.05% Cream/Ointment/ Gel/Solution

	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/Solution	**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/ Solution**	
		Mometasone 0.1% Cream/Ointment/ Solution	**Triamcinolone 0.5% Cream/Ointment**	
		Triamcinolone 0.025%, 0.1% Cream/Ointment/ Lotion		
		4 mcg/cm^2 tape		
		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	

LIMITATIONS

1. Requests for brand-name products, which have AB-rated generics, will be reviewed according to Brand Name criteria.
2. Requests for quantities that exceed the quantity limit will be reviewed according to the Quantity Limit criteria.

CODES

None

REFERENCES

1. Zyclara (imiquimod) [prescribing information]. Bridgewater, NJ: Valeant Pharmaceuticals; February 2018.
2. Picato (ingenol mebutate) [prescribing information]. Parsippany, NJ: Leo Pharma; February 2020.
3. Amini S, et al. Nonsurgical innovations in the treatment of nonmelanoma skin cancer. J Clin Aesthet Dermatol. 2010 Jun; 3(6):20-34.
4. De Berker D, McGregor JM, Hughes BR, British Association of Dermatologists Therapy Guidelines and Audit. Guidelines for the Management of Actinic Keratoses. Br J Dermatol 2007 Feb;156(2):222-30.
5. Stockfleth E, Terhorst D, Braathen L, Cribier B, Cerio R, Ferrandiz C et al. Guidelines For the Management of Actinic Keratoses. European Dermatology Forum. October 2010.

6. Leo Pharma Inc, Picato product information. Eden Prairie, MN. February 2012.
7. PR Newswire. FDA Approves Picato® (ingenol mebutate) Gel, the First and Only Topical Actinic Keratosis (AK) Therapy With 2 or 3 Consecutive Days of Once-Daily Dosing Source: http://s.tt/1bEBe.
8. Stockfleth E, Terhorst D, Braathen L, Cribier B, Cerio R, Ferrandiz C et al. Guidelines For the Management of Actinic Keratoses. European Dermatology Forum. October 2010.
9. National Comprehensive Cancer Network. Squamous Cell Skin Cancers. NCCN Guidelines Version 2.2012.
10. Aldara (imiquimod) [prescribing information]. Bridgewater, NJ: Valeant Pharmaceuticals; June 2017.
11. Solaraze (diclofenac 3% gel) [prescribing information]. Melville, NY: PharmDerm; March 2015.
12. Efudex (imiquimod 5% cream) [prescribing information]. Bridgewater, NJ: Valent Pharmaceuticals; May 2017.

APPROVAL HISTORY

December 9, 2014: Reviewed by Pharmacy & Therapeutics Committee. Consolidation of criteria for individual products; approval duration limited to one year for tacrolimus and pimecrolimus.

Subsequent endorsement date(s) and changes made:
1. November 10, 2015: Incorporated a table to include the topical immunomodulator medications and their coverage status; no change in clinical content.
2. January 1, 2016: Administrative change to rebranded template.
3. November 15, 2016: Removed vitiligo in a sun-exposed area of the skin as an approvable diagnosis for pimecrolimus or tacrolimus. Removed "requests for quantities that exceed the quantity limit will be reviewed according to the Quantity Limit criteria".
4. May 9, 2017: Administrative update, Adding Tufts Health RITogether to the template.
5. July 10, 2018: No changes.
6. June 11, 2019: Effective October 1, 2019, updated criteria for imiquimod 2.5% and 3.75% to be indication-specific. Updated list of preferred and nonpreferred topical corticosteroids to include fluticasone 0.05% lotion and 0.005% ointment as well as halobetasol 0.01% lotion. Administrative changes made to template.
7. May 12, 2020: Administrative update, updated the table of preferred and nonpreferred topical corticosteroids.
8. October 13, 2020: Removed diagnoses from criteria for pimecrolimus and tacrolimus.
9. November 24, 2020: Effective January 1, 2021, removed pimecrolimus and tacrolimus from the MNG.

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.