

Pharmacy Medical Necessity Guidelines: Impetigo Medications

Effective: April 14, 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
<p>These pharmacy medical necessity guidelines apply to the following:</p> <p>Commercial Products</p> <input type="checkbox"/> Tufts Health Plan Commercial products – large group plans <input type="checkbox"/> Tufts Health Plan Commercial products – small group and individual plans <input type="checkbox"/> Tufts Health Freedom Plan products – large group plans <input type="checkbox"/> Tufts Health Freedom Plan products – small group plans <ul style="list-style-type: none"> CareLinkSM – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization <p>Tufts Health Public Plans Products</p> <input type="checkbox"/> Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product) <input type="checkbox"/> Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans <input checked="" type="checkbox"/> Tufts Health RITogether – A Rhode Island Medicaid Plan		<p>Fax Numbers: RXUM: 617.673.0988</p>	

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

OVERVIEW

FDA-APPROVED INDICATIONS

Mupirocin 2% ointment is indicated for the treatment of impetigo due to *Staphylococcus aureus* and *Streptococcus pyogenes*.

Mupirocin 2% cream is indicated for the treatment of secondarily infected traumatic skin lesions (up to 10 cm in length or 100 cm² in area) caused by susceptible strains of *S. aureus* and *Streptococcus pyogenes*.

Retapamulin 1% ointment (Altabax) is indicated for the topical treatment of impetigo due to *Staphylococcus aureus* (methicillin-susceptible isolates only) or *Streptococcus pyogenes* in adults and children 9 months and older.

Ozenoxacin 1% cream (Xepi) is indicated for the topical treatment of impetigo due to *S. aureus* or *S. pyogenes* in adult and pediatric patients 2 months of age and older.

Medication	Preferred Drug List Status	Quantity Limit
Mupirocin 2% ointment (generic Bactroban)	Covered	n/a
Mupirocin 2% ointment (Centany)	PA	n/a
Mupirocin 2% cream (generic Bactroban)	PA	60gm per Rx
Retapamulin 1% ointment (Altabax)	ST*	30gm per Rx
Ozenoxacin 1% cream (Xepi)	PA	30 gram per Rx

*Step therapy requires prior use of mupirocin ointment within the last 28 days

COVERAGE GUIDELINES

The plan may authorize coverage of a non-preferred product indicated for impetigo for Members when **one** of the following criteria is met and limitations do not apply:

- The Member had an insufficient response to at least a 5-day course of therapy with mupirocin ointment within the last 28 days

OR

- The Member has a contraindication or has been intolerant to mupirocin ointment in the past, or the provider documents rationale for clinical inappropriateness of treatment with mupirocin ointment

LIMITATIONS

1. Approval will be limited to one year.
2. Requests for brand-name products, which have AB-rated generics, will be reviewed according to the Brand Name criteria.

CODES

None

REFERENCES

1. Bactroban (mupirocin calcium) ointment [prescribing information]. Research Triangle Park, NC: GlaxoSmithKline; March 2017.
2. Bactroban (mupirocin calcium) cream [prescribing information]. Research Triangle Park, NC: GlaxoSmithKline; February 2020.
3. Altabax (retapamulin) ointment [prescribing information]. Exton, PA: Almirall, SA; September 2019.
4. Xepi (ozenoxacin) cream [prescribing information]. Wayne, PA: Cutanea Life Sciences; January 2019.

APPROVAL HISTORY

December 9, 2014: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:

1. November 10, 2015: Incorporated a table with Preferred Drug List status; no changes in clinical content.
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. Added "requests for brand-name products, which have AB-rated generics, will be reviewed according to the Brand Name criteria" to the limitations section.
4. May 9, 2017: Administrative update. Effective 6/1/2017, Medical Necessity Guideline applies to Tufts Health RITogether.
5. November 14, 2017: No changes.
6. November 13, 2018: Administrative changes made to template.
7. May 6, 2019: Added Xepi (ozenoxacin) cream to Medical Necessity Guideline.
8. April 14, 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.

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