Pharmacy Medical Necessity Guidelines:
Taclonex® (calcipotriene 0.005%/betamethasone dipropionate 0.064%)

Effective: April 10, 2018

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<th>Prior Authorization Required</th>
<th>Type of Review – Care Management</th>
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<th>Type of Review – Clinical Review</th>
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<td>RX</td>
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This pharmacy medical necessity guideline applies to the following:

**Tufts Health Plan Commercial Plans**
- Tufts Health Plan Commercial Plans – large group plans
- Tufts Health Plan Commercial Plans – small group and individual plans

**Tufts Health Public Plans**
- Tufts Health Direct – Health Connector
- Tufts Health Together – A MassHealth Plan
- Tufts Health RITogether – A Rite Care + Rhody Health Partners Plan

**Tufts Health Freedom Plan products**
- Tufts Health Freedom Plan - large group plans
- Tufts Health Freedom Plan - small group plans

**Fax Numbers:**
- RXUM: 617-673-0988

**OVERVIEW**

**FDA-APPROVED INDICATIONS**
Taclonex (calcipotriene/betamethasone) ointment is indicated for the treatment of plaque psoriasis in patients 12 years and older.

Taclonex (calcipotriene/betamethasone) suspension is indicated for the treatment of plaque psoriasis of the scalp in patients 12 years and older, and of the body in adults.

**COVERAGE GUIDELINES**
The plan may authorize coverage of Taclonex (calcipotriene/betamethasone) ointment or suspension for Members when the following criterion is met and limitations do not apply:

1. The Member tried and failed or the provider indicates clinical inappropriateness of concomitant therapy with the individual agents, calcipotriene 0.005% and betamethasone 0.05%

**LIMITATIONS**
1. Requests for brand-name products, with AB-rated generics, will also be reviewed according to Brand Name Medications criteria.

**CODES**
None

**REFERENCES**
1. Taclonex (calcipotriene/betamethasone ointment) [prescribing information]. Parsippany, NJ: Leo Pharma Inc; December 2014.
2. Taclonex (calcipotriene/betamethasone suspension) [prescribing information]. Madison, NJ: Leo Pharma Inc; June 2017.

**APPROVAL HISTORY**
February 10, 2015: Reviewed by Pharmacy & Therapeutics Committee, approval duration is limited to one year.

Subsequent endorsement date(s) and changes made:
- September 16, 2015: Approval duration approved for life of plan.
- January 1, 2016: Administrative change to rebranded template.
- January 12, 2016: No changes.
- January 10, 2017: No changes.
- May 9, 2017: Administrative update, Adding Tufts Health RITogether to the template.
- April 10, 2018: 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. They are used in conjunction with a member’s benefit document and in coordination with the member’s physician(s). 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.

This Pharmacy Medical Necessity Guideline does not apply to Uniformed Services Family Health Plan members or to certain delegated service arrangements. Unless otherwise noted in the member’s benefit document or applicable Pharmacy Medical Necessity Guideline, Pharmacy Medical Necessity Guidelines do not apply to CareLink℠ members. For self-insured plans, drug coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a coverage guideline and a self-insured member’s benefit document, the provisions of the benefit document will govern. Applicable state or federal mandates will take precedence.

For Tufts Health Plan Medicare Preferred, please refer to Tufts Health Plan Medicare Preferred Prior Authorization Criteria.

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.