Topical Immunomodulators
Eucrisa (crisaborole)
Effective January 1, 2021

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**Specialty Limitations**
N/A

**Specialty Medications**
All Plans
Phone: 866-814-5506
Fax: 866-249-6155

**Non-Specialty Medications**
MassHealth
Phone: 877-433-7643
Fax: 866-255-7569

Commercial
Phone: 800-294-5979
Fax: 888-836-0730

Exchange
Phone: 855-582-2022
Fax: 855-245-2134

**Medical Specialty Medications (NLX)**
All Plans
Phone: 844-345-2803
Fax: 844-851-0882

**Overview**
N/A

**No PA**

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<th>Drugs that require PA</th>
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<tr>
<td>Elidel® (pimecrolimus) §</td>
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<tr>
<td>Eucrisa® (crisaborole) PD</td>
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<td>Protopic® (tacrolimus topical) §</td>
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*PD* Preferred Drug: A trial of the preferred drug or clinical rationale for prescribing a non-preferred drug within a therapeutic class. Please note, for Immune Suppressants – Topical agents, a trial with a preferred agent is not required prior to approval of a non-preferred agent.

*§* Brand Preferred over generic equivalents: A trial of the preferred drug or clinical rationale for prescribing the non-preferred drug generic equivalent.

**Coverage Guidelines**
Prescriber provides documentation of **ALL** of the following:

1. The member has a diagnosis of atopic dermatitis
2. The member is ≥3 months of age
3. The member meets ONE of the following:
   a. Inadequate response or adverse reaction to **ONE** topical corticosteroid **OR** topical calcineurin inhibitor (e.g. pimecrolimus or tacrolimus)
   b. Contraindication to **BOTH** topical corticosteroids and topical calcineurin inhibitors
4. **ONE** of the following:
   a. Request is for 60 gram/month. If the request does not document quantity, may be approved for the 60 gram/month if member meets criteria.
   b. Medical necessity for exceeding the quantity limits (i.e. large surface area of lesion)
Limitations
1. Initial approvals and reauthorizations will be granted for 12 months
2. The following quantity limits apply:

| 1. Eucrisa | 2. 60 grams per 30 days |

Brand preferred over generic equivalent
In addition to any prior authorization requirements, generic medications listed below require a trial of the preferred drug or clinical rationale for prescribing the non-preferred drug generic equivalent.
- Pimecrolimus
- Tacrolimus topical

References
1. Eucrisa Ointment 2% (crisaborole) [prescribing information]. New York, NY: Pfizer Labs; April 2020.

Review History
10/01/2020 – Updated MH partial unified formulary; retired ST criteria and switched to PA; added Eucrisa PA criteria, added QL, Effective 1/1/2021

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