allways[sm]
HEALTH PARTNERS

Topical Immunomodulators
Eucrisa (crisaborole)
Effective January 1, 2021

Plan	☐ MassHealth ☒ MassHealth (PUF) ☐Commercial/Exchange	**Program Type**	☒ Prior Authorization ☒ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☐ Medical Benefit (NLX)		
Specialty Limitations	N/A		
Contact Information	**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
Exceptions	N/A		

Overview

No PA	Drugs that require PA
Elidel® (pimecrolimus) §	Eucrisa® (crisaborole) [PD]
Protopic® (tacrolimus topical) §	

[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 $\geq$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.
2. Protopic (tacrolimus) [prescribing information]. Madison, NJ: LEO Pharma Inc.; February 2019.
3. Elidel (pimecrolimus) [prescribing information]. Bridgewater, NJ: Valeant Pharmaceuticals; December 2017.

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

Disclaimer

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