



**Eucrisa (crisaberole)  
Opzelura (ruxolitinib)  
Effective 03/01/2022**

<b>Plan</b>	<input type="checkbox"/> MassHealth <input checked="" type="checkbox"/> Commercial/Exchange	<b>Program Type</b>	<input checked="" type="checkbox"/> Prior Authorization
<b>Benefit</b>	<input checked="" type="checkbox"/> Pharmacy Benefit <input type="checkbox"/> Medical Benefit (NLX)		<input checked="" type="checkbox"/> Quantity Limit <input type="checkbox"/> Step Therapy
<b>Specialty Limitations</b>	N/A		
<b>Contact Information</b>	<b>Specialty Medications</b>		
	All Plans	Phone: 866-814-5506	Fax: 866-249-6155
	<b>Non-Specialty Medications</b>		
	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	
	<b>Medical Specialty Medications (NLX)</b>		
	All Plans	Phone: 844-345-2803	Fax: 844-851-0882
<b>Exceptions</b>	N/A		

**Overview**

Crisaborole is a topical phosphodiesterase-4 (PDE-4) inhibitor indicated for treatment of mild to moderate atopic dermatitis in adults and pediatric patients at least 3 months of age.

Opzelura is indicated for the topical short-term and non-continuous chronic treatment of mild to moderate atopic dermatitis in non-immunocompromised patients 12 years of age and older whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable.

**Coverage Guidelines**

Authorization may be granted for members new to AllWays Health Partners who are currently receiving treatment with the requested medication excluding when the product is obtained as samples or via manufacturer’s patient assistance programs.

**OR**

Authorization may be granted for members when ALL the following criteria are met, and documentation is provided:

**Eucrisa**

1. The member is diagnosed with mild to moderate atopic dermatitis
2. The member is at least 3 months old
3. The member meets ONE of the following:
  - a. The member has experienced an inadequate response or intolerance to a medium or higher potency topical corticosteroid or a topical calcineurin inhibitor



- b. The member has a contraindication to both topical corticosteroids and topical calcineurin inhibitors

**Opzelura**

1. The drug is being used for topical short-term and non-continuous chronic treatment of mild to moderate atopic dermatitis
2. Physician attestation that atopic dermatitis is limited to no more than 20% body surface area (BSA)
3. The member is 12 years of age or older
4. The member meets ONE of the following:
  - a. The member is using medication on a sensitive skin area (e.g., face, genitals, or skin folds) AND has inadequate response, intolerance, or contraindication to a topical calcineurin inhibitor (e.g., tacrolimus or pimecrolimus)
  - b. The member has inadequate response, intolerance, or contraindication to a topical calcineurin inhibitor (e.g., tacrolimus or pimecrolimus) AND a medium or high potency topical corticosteroid (see Appendix A)
5. The member has inadequate response, intolerance, or contraindication to Eucrisa (crisaberole)

**Continuation of Therapy**

Reauthorizations requires physician documentation of continuation of therapy and maintained positive response to therapy as evidenced by improvement [e.g., improvement in or resolution of any of the following signs and symptoms: erythema (redness), exudation (oozing and crusting), excoriation (evidence of scratching), induration (hardening)/papulation (formation of papules), lichenification (epidermal thickening), or pruritis (itching)].

**Limitations**

1. For Eucrisa: Initial approvals and reauthorizations will be granted for 12 months.
2. For Ozelura:
  - a. Initial approvals will be granted for 3 months
  - b. Reauthorizations will be granted for 12 months
  - c. For all indications: Member has a pretreatment tuberculosis (TB) screening with a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB).
    - i. Note: Members who have received Opzelura or any other biologic DMARD or targeted synthetic DMARD (e.g., Xeljanz) are exempt from requirements related to TB screening in this Policy.
3. The following quantity limits apply:

Eucrisa	60 gam per 30 days
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**Appendix**

**Appendix A: Topical Corticosteroid Reference (not all inclusive)**

Very High Potency	Dosage Form	Strength
augmented betamethasone dipropionate (Diprolene)	Ointment	0.05%
clobetasol propionate (Temovate, Olux)	Cream, Gel, Ointment, Sol, Foam	0.05%
diflorasone diacetate (Psorcon)	Ointment	0.05%
High Potency	Dosage Form	Strength
amcinonide	Cream, Lotion, Ointment	0.1%

augmented betamethasone dipropionate (Diprolene AF)	Cream	0.05%
Betamethasone dipropionate	Cream, Ointment	0.05%
Betamethasone valerate	Ointment	0.1%
Desoximetasone (Topicort)	Cream, Ointment	0.25%
Desoximetasone (Topicort)	Cream, Gel	0.05%
diflorasone diacetate (Psorcon)	Cream	0.05%
Fluocinonide	Cream, Gel, Ointment, Solution	0.05%
Fluocinonide emollient base	Cream	0.05%
Triamcinolone acetonide (Kenalog)	Cream, Ointment	0.5%
<b>Medium Potency</b>	<b>Dosage Form</b>	<b>Strength</b>
Betamethasone dipropionate (Diprosone)	Lotion	0.05%
Betamethasone valerate	Cream, Lotion	0.1%
Desoximetasone (Topicort LP)	Cream	0.05%
Fluocinolone acetonide (Synalar)	Cream, Ointment	0.025%
Hydrocortisone valerate	Cream, Ointment	0.2%
Mometasone furoate (Elocon)	Ointment	0.1%
Triamcinolone acetonide (Kenalog)	Cream, Lotion, Ointment	0.025%
Triamcinolone acetonide (Kenalog)	Cream, Lotion, Ointment	0.1%

## References

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6. Svensson A, Chambers C, Gånemo A, Mitchell SA. A systematic review of tacrolimus ointment compared with corticosteroids in the treatment of atopic dermatitis. *Curr Med Res Opin* 2011; 27:1395
7. Li AW, Yin ES, Antaya RJ. Topical Corticosteroid Phobia in Atopic Dermatitis: A Systematic Review. *JAMA Dermatol* 2017; 153:1036
8. Choi JY, Dawe R, Ibbotson S, et al. Quantitative analysis of topical treatments in atopic dermatitis: unexpectedly low use of emollients and strong correlation of topical corticosteroid use both with depression and concurrent asthma. *Br J Dermatol* 2020; 182:1017
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13. Eichenfield LF, Tom WL, et. al. Guidelines of care for the management of atopic dermatitis: Section 2. Management and treatment of atopic dermatitis with topical therapies. *J Am Acad Dermatol* 2014; 71:116-32.
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### **Review History**

07/21/2021- Reviewed at July P&T; Switched from CVS Standard criteria to AllWays Health Partners custom template.

01/19/2022 – Reviewed and updated for Jan P&T; added new drug Opzelura to criteria. Reauthorization criteria was clarified to include examples of positive response to therapy (improvement in erythema, exudation, excoriation, induration/papulation, lichenification, or pruritis). Effective 03/01/2022

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