Eucrisa (crisaborole)

NOTICE

This policy contains information which is clinical in nature. The policy is not medical advice. The information in this policy is used by Wellmark to make determinations whether medical treatment is covered under the terms of a Wellmark member's health benefit plan. Physicians and other health care providers are responsible for medical advice and treatment. If you have specific health care needs, you should consult an appropriate health care professional. If you would like to request an accessible version of this document, please contact customer service at 800-524-9242.

BENEFIT APPLICATION

Benefit determinations are based on the applicable contract language in effect at the time the services were rendered. Exclusions, limitations or exceptions may apply. Benefits may vary based on contract, and individual member benefits must be verified. Wellmark determines medical necessity only if the benefit exists and no contract exclusions are applicable. This policy may not apply to FEP. Benefits are determined by the Federal Employee Program.

DESCRIPTION

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications

Eucrisa is indicated for topical treatment of mild to moderate atopic dermatitis in patients 3 months of age and older.

POLICY

Criteria for Initial Approval

A. Eucrisa may be considered **medically necessary** when the following criteria are met:

- The requested drug is being prescribed for a patient 3 months of age or older for mild to moderate atopic dermatitis

AND

- The patient is less than 2 years of age

OR

- The requested drug will be used on sensitive skin areas (e.g., face, genitals, or skin folds)

AND

- The patient experienced an inadequate treatment response, intolerance, or contraindication to a topical calcineurin inhibitor

OR

- The patient experienced an inadequate treatment response, intolerance, or contraindication to a topical calcineurin inhibitor and a medium or higher potency topical corticosteroid

Approval will be for **3 months** with a quantity limit not to exceed 60 gm per 30 days. Coverage for 120 gm per 30 days will be provided when 5% or greater body surface area is affected

Continuation of Therapy

The continuation of Eucrisa may be considered medically necessary when the following criteria are met:

- The requested drug is being prescribed for continuation of therapy, and the patient achieved or maintained a positive clinical response as evidenced by improvement [(e.g., improvement in or resolution of any of the following signs and symptoms: erythema (redness), edema (swelling, xerosis (dry skin), erosions, excoriation (evidence of scratching), oozing and crusting, lichenification (epidermal thickening), OR pruritus (itching)]

Approval will be for **12 months** with a quantity limit not to exceed 60 gm per 30 days. Coverage for 120 gm per 30 days will be provided when 5% or greater body surface area is affected

Dosing and Administration

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Quantity Limits

60 gm per 30 days or 120 gm per 30 days when 5% or greater body surface area is affected.

PROCEDURES AND BILLING CODES

To report provider services, use appropriate CPT* codes, Alpha Numeric (HCPCS level 2) codes, Revenue codes, and/or ICD diagnostic codes.

- Code(s), if applicable

REFERENCES

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POLICY HISTORY

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