Reference number(s)
3199-E

This document applies to the following:

Formulary	Applies
Advanced Control (ACF)	☐
Advanced Control Formulary Chart (ACFC)	☐
Advanced Control – Choice (ACCF)	☐
Basic Control (BC)	☐
Basic Control Chart (BCC)	☐
Standard Control (SF)	☐
Standard Control Formulary Chart (SFC)	☐
Standard Control – Choice (SCCF)	☐
Value (VF)	☐
Value Formulary Chart (VFC)	☐

Formulary	Applies
Managed Medicaid Template (MMT)	☐
Marketplace (MF)	☑
Aetna Small Group Affordable Care Act (SG ACA) Aetna Health Exchange (AHE)	☑
Aetna Individual Lives (IVL)	☑
Aetna Fully Insured Advanced Control Formulary (Aetna FI ACF)	☐
Aetna Fully Insured Advanced Control Formulary Chart (Aetna FI ACFC)	☐
Aetna Fully Insured Standard Opt-Out (Aetna FI SOO)	☐

Initial Step Therapy with Quantity Limit; Post Step Therapy Prior Authorization with Quantity Limit

Eucrisa

Products Referenced by this Document

Drugs that are listed in the following table include both brand and generic and all dosage forms and strengths unless otherwise stated. Over-the-counter (OTC) products are not included unless otherwise stated.

Brand Name	Generic Name
Eucrisa	crisaborole

Indications

FDA-approved Indications

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

Initial Step Therapy with Quantity Limit

Include Prescription (Rx) and Over-the-counter (OTC) products unless otherwise stated.

If the patient has filled a prescription for at least a one day supply of a medium or higher potency topical corticosteroid within the past 180 days (see Table 1) under a prescription benefit administered by CVS Caremark, then the requested drug will be paid under that prescription benefit. If the patient does not meet the initial step therapy criteria, then the claim will reject with a message indicating that a prior authorization (PA) is required. The prior authorization criteria would then be applied to requests submitted for evaluation to the PA unit.

If the patient meets the initial step therapy criteria, then a quantity limit will apply. If the patient is requesting more than the initial quantity limit, the claim will reject with a message indicating that a PA is required.

Initial Limit Quantity

The duration of 25 days is used for a 30-day fill period and 75 days is used for a 90-day fill period to allow time for refill processing.

Drug	1 Month Limit	3 Month Limit
Eucrisa (crisaborole)	60 grams / 25 days	180 grams / 75 days

Table 1: Examples of Topical Corticosteroids for Treatment of Atopic Dermatitis [2,3,4]

Potency	Drug
Medium Potency	betamethasone dipropionate lotion, spray 0.05%
Medium Potency	betamethasone valerate cream/lotion 0.1%/foam 0.12%
Medium Potency	clocortolone pivalate cream 0.1%
Medium Potency	desonide lotion, ointment 0.05%
Medium Potency	desoximetasone cream 0.05%
Medium Potency	fluocinolone acetonide cream/ointment/kit 0.025%
Medium Potency	flurandrenolide cream/ointment/lotion 0.05%
Medium Potency	fluticasone propionate cream/lotion 0.05%/ointment 0.005%
Medium Potency	hydrocortisone butyrate cream/lipocream/lotion/ointment/solution 0.1%
Medium Potency	hydrocortisone probutate cream 0.1%
Medium Potency	hydrocortisone valerate cream/ointment 0.2%

Potency	Drug
Medium Potency	mometasone furoate cream/lotion/solution 0.1%
Medium Potency	prednicarbate cream/ointment 0.1%
Medium Potency	triamcinolone acetonide cream/ointment/lotion/kit 0.1%
Medium Potency	triamcinolone acetonide cream/ointment/lotion 0.025%
Medium Potency	triamcinolone acetonide ointment 0.05%
High Potency	amcinonide cream/ointment/lotion 0.1%
High Potency	betamethasone dipropionate cream/ointment 0.05%
High Potency	betamethasone dipropionate augmented cream/lotion 0.05%
High Potency	betamethasone valerate ointment 0.1%
High Potency	desoximetasone cream/ointment/spray 0.25%/gel/ointment 0.05%
High Potency	diflorasone diacetate cream (emollient base) 0.05% diflorasone cream 0.05%
High Potency	halcinonide cream/ointment 0.1%
High Potency	fluocinonide cream/emulsified cream/ointment/gel/solution 0.05%
High Potency	mometasone furoate ointment 0.1%
High Potency	triamcinolone acetonide aerosol solution 0.147 mg/g
High Potency	triamcinolone acetonide cream/ointment 0.5%
Very High Potency	betamethasone dipropionate augmented ointment/gel 0.05%
Very High Potency	clobetasol propionate cream/ointment/foam/shampoo/gel/lotion/solution/spray 0.05%/cream 0.025%
Very High Potency	diflorasone diacetate ointment 0.05%
Very High Potency	flurandrenolide tape 4mcg/cm2
Very High Potency	halobetasol propionate cream/ointment/lotion/kit 0.05%
Very High Potency	fluocinonide cream 0.1%

Coverage Criteria

Atopic Dermatitis

Authorization may be granted when the requested drug is being prescribed for mild to moderate atopic dermatitis when ALL of the following criteria are met:

- The patient is 3 months of age or older.
- The patient meets ONE of the following criteria:
  - The patient is less than 2 years of age.
  - The requested drug will be used on sensitive skin areas (e.g., face, genitals, or skin folds).
  - The patient experienced an inadequate treatment response to a medium or higher potency topical corticosteroid.

  - The patient experienced an intolerance to a medium or higher potency topical corticosteroid.
  - The patient has a contraindication that would prohibit a trial of a medium or higher potency topical corticosteroid.
- If additional quantities are being requested, then 5 percent or greater body surface area is affected.

Continuation of Therapy

Atopic Dermatitis

Authorization may be granted when the requested drug is being prescribed for mild to moderate atopic dermatitis when ALL of the following criteria are met:

- The patient is 3 months of age or older.
- The patient has 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, excoriations (evidence of scratching), oozing and crusting, lichenification (epidermal thickening), OR pruritus (itching)].
- If additional quantities are being requested, then 5 percent or greater body surface area is affected.

Quantity Limits Apply

60 grams per 25 days or 180 grams per 75 days.

5% or greater Body Surface Area (BSA): 120 grams per 25 days or 360 grams per 75 days.

The duration of 25 days is used for a 30-day fill period and 75 days is used for a 90-day fill period to allow time for refill processing.

Duration of Approval (DOA)

- 3199-E: Initial therapy DOA: 3 months; Continuation of therapy DOA: 12 months

References

1. Eucrisa [package insert]. New York, NY: Pfizer Inc.; April 2023.
2. Lexicomp Online, AHFS DI (Adult and Pediatric) Online. Waltham, MA: UpToDate, Inc.; 2025. https://online.lexi.com. Accessed February 5, 2025.
3. Micromedex® (electronic version). Merative, Ann Arbor, Michigan, USA. Available at: https://www.micromedexsolutions.com/ (cited: 02/05/2025).

4. 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.
5. Paller AS, Tom WL, et. al. Efficacy and safety of crisaborole ointment, a novel, nonsteroidal phosphodiesterase 4 (PDE4) inhibitor for the topical treatment of atopic dermatitis (AD) in children and adults. J Am Acad Dermatol. 2016 Jul 11;75(3)494-503.e4.
6. U.S. Department of Health & Human Services. Burn Triage and Treatment – Thermal Injuries. Chemical Hazards Emergency Medical Management. December 26, 2024. Available at: https://chemm.hhs.gov/burns.htm. Accessed February 6, 2025.
7. Eichenfield LF, Tom WL, et. al. Guidelines of Care for the Management of Atopic Dermatitis: Section 1. Diagnosis and assessment of atopic dermatitis. J Am Acad Dermatol 2014; 70:338-51.
8. Sidbury RS, Alikhan A, Berovitch L, et al. Guidelines of care for the management of atopic dermatitis in adults with topical therapies. J Am Acad Dermatol. 2023: 89(1): e1-e20.

