STEP THERAPY CRITERIA

BRAND NAME
(generic)

EUCRISA
(crisaborole)

Status: CVS Caremark Criteria
Type: Initial Step Therapy with Quantity Limit;
Post Step Therapy Prior Authorization with Quantity Limit

POLICY

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 Rx and 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 CRITERIA**

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

TABLE 1: EXAMPLES OF TOPICAL CORTICOSTEROIDS FOR TREATMENT OF ATOPIC DERMATITIS [2,3,4]	
Medium Potency	betamethasone dipropionate lotion, spray 0.05%
	betamethasone valerate cream/lotion 0.1%/foam 0.12%
	clocortolone pivalate cream 0.1%
	desonide lotion, ointment 0.05%
	desoximetasone cream 0.05%
	fluocinolone acetonide cream/ointment/kit 0.025%
	flurandrenolide cream/ointment/lotion 0.05%
	fluticasone propionate cream/lotion 0.05%/ointment 0.005%
	hydrocortisone butyrate cream/lipocream/lotion/ointment/solution 0.1%
	hydrocortisone probutate cream 0.1%
	hydrocortisone valerate cream/ointment 0.2%
	mometasone furoate cream/lotion/solution 0.1%
	prednicarbate cream/ointment 0.1%

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

COVERAGE CRITERIA

The requested drug will be covered with prior authorization when the following criteria are met:

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

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)

OR

  - The patient experienced an inadequate treatment response to a medium or higher potency topical corticosteroid

    OR
  - The patient experienced an intolerance to a medium or higher potency topical corticosteroid

    OR
  - The patient has a contraindication that would prohibit a trial of a medium or higher potency topical corticosteroid

AND

- If additional quantities are being requested, then 5 percent or greater body surface area is affected

OR

- The request is for continuation of therapy, and the patient achieved or maintained positive clinical response 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 pruritus (itching)]

AND

- If additional quantities are being requested, then 5 percent or greater body surface area is affected

Quantity Limits Apply.
60 gm per 25 days or 180 gm per 75 days
For greater than 5% body surface area: 120 grams per 25 days or 360 grams per 75 days

REFERENCES

1. Eucrisa [package insert]. New York, NY: Pfizer Inc.; April 2020.

2. Lexicomp Online, AHFS DI (Adult and Pediatric) Online, Hudson, Ohio: UpToDate, Inc.; 2022; Accessed February 25, 2021.
3. Micromedex (electronic version). IBM Watson Health, Greenwood Village, Colorado, USA. Available at: https://www.micromedexsolutions.com. Accessed February 25, 2021.
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. August 16, 2021. Available at: https://chemm.hhs.gov/burns.htm. Accessed February 11, 2022.

