PRIOR AUTHORIZATION CRITERIA

BRAND NAME
(generic)

ELIDEL
(pimecrolimus)

Status: CVS Caremark® Criteria
Type: Initial Prior Authorization with Logic

POLICY

FDA-APPROVED INDICATIONS

Elidel (pimecrolimus) Cream, 1% is indicated as second-line therapy for the short-term and non-continuous chronic treatment of mild to moderate atopic dermatitis in non-immunocompromised adults and children 2 years of age and older, who have failed to respond adequately to other topical prescription treatments, or when those treatments are not advisable.
Elidel Cream, 1% is not indicated for use in children less than 2 years of age.

Compendial Uses
Psoriasis[3] - on the face, genitals, or skin folds[6]
Atopic Dermatitis for patients under 2 years of age[4, 5]
Vitiligo on the head or neck[7, 8]

SCREEN OUT LOGIC*

**Include Rx and OTC products unless otherwise stated.*

If the patient has filled a prescription for at least a 14 day supply of at least one corticosteroid of medium or higher potency within the past 180 days (see examples in 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 screen out logic, 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.

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

	triamcinolone acetonide ointment 0.05%
High Potency	amcinonide crm/oint/lotion 0.1%
	betamethasone dipropionate crm/oint 0.05%
	betamethasone dipropionate augmented crm/lotion 0.05%
	betamethasone valerate oint 0.1%
	desoximetasone crm/oint/spray 0.25%/gel/oint 0.05%
	diflorasone diacetate crm (emollient base) 0.05% diflorasone cream 0.05%
	halcinonide crm/oint 0.1%
	fluocinonide crm/emulsified cream/oint/gel/soln 0.05%
	mometasone furoate oint 0.1%
	triamcinolone acetonide crm/oint 0.5%
	triamcinolone acetonide aerosol soln 0.147 mg/g
Very High Potency	betamethasone dipropionate augmented oint/gel 0.05%
	clobetasol propionate crm/oint/foam/shampoo/gel/lotion/soln/spray 0.05%/cream 0.025%
	diflorasone diacetate oint 0.05%
	flurandrenolide tape 4mcg/cm^2
	halobetasol propionate crm/oint/lotion/kit 0.05%
	fluocinonide crm 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 psoriasis on the face, genitals, or skin folds
  AND
  - The request is NOT for continuation of therapy
  OR
  - The request is for continuation of therapy
    AND
    - The patient has achieved or maintained a positive clinical response as evidenced by improvement (e.g., clear, or almost clear outcome, patient satisfaction, etc.)

OR

- The requested drug is being prescribed for vitiligo on the head or neck
  AND
  - The request is NOT for continuation of therapy
  OR
  - The request is for continuation of therapy
    AND
    - The patient has achieved or maintained a positive clinical response as evidenced by improvement (e.g., meaningful repigmentation)

OR

- The requested drug is being prescribed for the short-term and non-continuous chronic treatment of mild to moderate atopic dermatitis (eczema)
  AND
  - The request is NOT for continuation of therapy
    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 has experienced an inadequate treatment response, intolerance, or contraindication to at least one first line therapy agent (e.g., medium or higher potency topical corticosteroid)

  OR
  - The request is for continuation of therapy
    AND

- 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)]

REFERENCES

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7. Kubelis-López DE, Zapata-Salazar NA, et al. Updates and new medical treatments for vitiligo (Review). *Exp Ther Med*. 2021;22(2):797.
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