PRIOR AUTHORIZATION CRITERIA

BRAND NAME (generic)

XEPI (ozenoxacin)

Status: CVS Caremark Criteria

Type: Initial Prior Authorization with Quantity Limit

POLICY

FDA-APPROVED INDICATIONS

Xepi is indicated for the topical treatment of impetigo due to *Staphylococcus aureus* or *Streptococcus pyogenes* in adult and pediatric patients 2 months of age and older.

COVERAGE CRITERIA

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

• The requested drug is being prescribed for the topical treatment of impetigo due to *Staphylococcus aureus* or *Streptococcus pyogenes* in a patient 2 months of age or older

AND

- The patient has experienced an inadequate treatment response to a trial of topical mupirocin OR
- The patient has experienced an intolerance to topical mupirocin
- The patient has a contraindication that would prohibit a trial of topical mupirocin

AND

The requested drug is not being used in a footbath

Quantity Limits apply.

30 grams per 25 days*

*This drug is for short-term acute use; therefore, the mail limit will be the same as retail limit. The intent is for prescriptions of the requested drug to be filled one month at a time, even if filled at mail order; there should be no 3-month supplies filled.

REFERENCES

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- 4. Stevens DL, Bisno AL, Chambers HF, et al: Practice guidelines for the diagnosis and management of skin and soft tissue infections: 2014 Update by the Infectious Diseases Society of America. *Clin Infect Dis* 2014;59(2):e10-e52.
- Hartman-Adams H, Banvard C, Juckett G. Impetigo: Diagnosis and Treatment. Am Fam Physician. 2014;90(4):229-235.
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Xepi PA with Limit 5466-C Policy 10-2022

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