



Wellmark Blue Cross and Blue Shield is an Independent Licensee of the Blue Cross and Blue Shield Association.

## DRUG POLICY

# 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 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)]

**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

- Eucrisa [package insert]. New York, NY: Pfizer Inc.; March 2020.
- Lexicomp Online, AHFS DI (Adult and Pediatric) Online. Hudson, OH: Wolters Kluwer Clinical Drug Information, Inc. <http://online.lexi.com/>. Accessed March 2020.
- Micromedex (electronic version). Truven Health Analytics, Greenwood Village, Colorado, USA. <http://www.micromedexsolutions.com/>. Accessed March 2020.
- 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.
- 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.
- Dermatologic Therapies-Basic Dermatology Curriculum. American Academy of Dermatology. June 8, 2011.
- <https://www.aad.org/File%20Library/Global%20navigation/Education%20and%20quality%20care/Basic%20Dermatology%20Curriculum/Dermatologic-Therapies.pptx>

## POLICY HISTORY

**Policy #:** 05.02.51

**Original Effective Date:** December 3, 2018

**Reviewed:** October 2022

**Revised:** June 2020

**Current Effective Date:** June 20, 2020