Pharmacy Medical Necessity Guidelines
Immunomodulators, Topical
Zyclara (Imiquimod 2.5% and 3.75%); Picato (Ingenol 0.015%, 0.05%); Elidel (Pimecrolimus 1%); Protopic (Tacrolimus 0.03%, 0.1%)

Effective: 4/1/15

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<thead>
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<th>Clinical Documentation and Prior Authorization Required</th>
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<th>Type of Review – Case Management</th>
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<td>Not Covered</td>
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<td>Fax: 617-673-0956</td>
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<td>Pharmacy (RX) or Medical (MED) Benefit</td>
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OVERVIEW

FDA-APPROVED INDICATIONS
Imiquimod is indicated for:
- Actinic keratosis (all strengths): For the topical treatment of clinically typical, nonhyperkeratotic, nonhypertrophic, visible or palpable actinic keratoses on the full face or balding scalp in immunocompetent adults.
- Genital and perianal warts (3.75% and 5% cream only): For the treatment of external genital and perianal warts (condyloma accuminata) in patients 12 years and older.
- Superficial basal cell carcinoma (5% cream only): For the topical treatment of biopsy-confirmed, primary superficial basal cell carcinoma in immunocompetent adults with a maximum tumor diameter of 2 cm located on the trunk (excluding anogenital skin), neck, or extremities (excluding hands and feet), when surgical methods are medically less appropriate and patient follow-up can be reasonably ensured.

Ingenol is indicated for the topical treatment of actinic keratosis.

Pimecrolimus is indicated as second-line therapy for short-term and noncontinuous long-term treatment of mild to moderate atopic dermatitis in nonimmunocompromised patients 2 years and older who have failed to respond adequately to other topical prescription treatments, or when those treatments are not advisable.

Tacrolimus ointment, both 0.03% and 0.1% for adults, and only 0.03% for children aged 2 to 15 years, is indicated as second-line therapy for the short-term and non-continuous chronic treatment of moderate to severe atopic dermatitis in non-immunocompromised adults and children who have failed to respond adequately to other topical prescription treatments for atopic dermatitis, or when those treatments are not advisable.

For actinic keratosis, imiquimod (Zyclara®) 2.5% and 3.75% treatment consists of up to 2 packets or pumps per day for two 14-day cycles separated by a 14-day rest period with no treatment; dosing should not to exceed 56 packets or pumps per complete course of treatment (two 14-day cycles).

Fluorouracil 5% cream, imiquimod 5% cream and diclofenac 3% gel (Solaraze) are preferred products and are covered without prior authorization.

PHARMACY COVERAGE GUIDELINES
Tufts Health Plan – Network Health may authorize coverage of topical immunomodulators for members when the following criteria for a particular regimen are met and limitations do not apply:

Imiquimod 2.5% or 3.75% (Zyclara®)
- The member had an insufficient response to therapy, or the provider indicated clinical inappropriateness of therapy with the preferred products, imiquimod 5% and fluorouracil

Ingenol (Picato)
- The member had an insufficient response to therapy or the provider indicated clinical inappropriateness of therapy with the preferred product, fluorouracil
Pimecrolimus or Tacrolimus
- The member is at least 2 years of age
- The request is for one of the following conditions:
  - Atopic dermatitis (eczema)
  - Lichen planus
  - Vitiligo in a sun-exposed area of the skin
- The member had an insufficient response to two topical anti-inflammatory agents of medium potency or greater, or the member is not a candidate for medium to high potency corticosteroid therapy (e.g., eyelid dermatitis or dermatitis associated with genital area eruptions)

<table>
<thead>
<tr>
<th>Preferred Products</th>
<th>Low Potency</th>
<th>Medium Potency</th>
<th>High Potency</th>
<th>Very High Potency</th>
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<tbody>
<tr>
<td></td>
<td>Alclometasone 0.05% Cream/Ointment</td>
<td>Betamethasone Valerate 0.1% Cream</td>
<td>Betamethasone Dipropionate 0.05% Cream/Ointment</td>
<td>Betamethasone Dip. Augmented 0.05% Ointment/Gel</td>
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<td></td>
<td>Fluocinolone 0.01% Cream</td>
<td>Betamethasone Dipropionate 0.05% Lotion</td>
<td>Betamethasone Dip., Augmented 0.05% Cream</td>
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<td>Hydrocortisone 0.5%, 1%, 2.5% Cream/Ointment/Lotion/Solution</td>
<td>Fluocinolone 0.025% Cream/Ointment</td>
<td>Betamethasone Valerate 0.1% Ointment</td>
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<td>Fluticasone 0.05% Cream/ointment</td>
<td>Desoximetasone 0.25% Cream/Ointment</td>
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<td></td>
<td>Hydrocortisone Valerate 0.2% Cream</td>
<td>Fluocinonide 0.05% Cream/Ointment/Gel/Soln</td>
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<td>Mometasone 0.1% Cream/Oint/Soln</td>
<td>Triamcinolone 0.5% Cream/Ointment</td>
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<td></td>
<td>Triamcinolone 0.025%, 0.1% Cream/Ointment/Lotion</td>
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<td>Non-Preferred Products</td>
<td>Desonide 0.05% Cream/Lotion/Ointment</td>
<td>Flurandrenolide 0.025%, 0.05% Cream/Oint; 4 mcg/cm² tape</td>
<td>Acmionide 0.01% Cream/Lotion/Ointment</td>
<td>Clobetasol 0.05% Cream/Ointment/ Gel/Solution</td>
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<td>Clocortolone 0.1% Cream</td>
<td>Desoximetasone 0.05% Gel</td>
<td>Diflorasone 0.05% Ointment</td>
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<tr>
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<td>Diflorasone 0.05% Cream</td>
<td>Flucinonide 0.1% Cream</td>
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<td></td>
<td>Hydrocortisone Butyrate Cream/Ointment/Solution</td>
<td>Halcinonide 0.1% Cream/Ointment</td>
<td>Halobetasol 0.05% Cream/Ointment</td>
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**LIMITATIONS**
Requests for brand-name products, which have AB-rated generics, will be reviewed according to Brand Name criteria. Approval of tacrolimus ointment for members 2 to 15 years of age will be limited to the 0.03% strength.
Quantity limits apply:
- Pimecrolimus and tacrolimus- one tube per Rx
- Zyclara – 2 month supply dispensed as 28 packets per 14 days or two pumps per day
- Picato – One box for a single course of treatment
Requests for quantities that exceed the quantity limit will be reviewed according to the Quantity Limit criteria.

**CODES**
None

**REFERENCES**
9. PR Newswire. FDA Approves Picato® (ingenol mebutate) Gel, the First and Only Topical Actinic Keratosis (AK) Therapy With 2 or 3 Consecutive Days of Once-Daily Dosing Source: http://s.tt/1bEBe.

**APPROVAL HISTORY**
- 12/9/14: Reviewed by the Pharmacy and Therapeutics Committee. Consolidation of criteria for individual products; approval duration limited to one year for tacrolimus and pimecrolimus.

**BACKGROUND, PRODUCT, AND DISCLAIMER INFORMATION**
Pharmacy Medical Necessity Guidelines have been developed for determining coverage for Tufts Health Plan – Network Health benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. They are used in conjunction with the applicable Member Handbook and in coordination with the member’s physician(s). Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the Tufts Health Plan – Network Health service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. Tufts Health Plan – Network Health reviews Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

Pharmacy Medical Necessity Guidelines apply to all fully insured Tufts Health Plan – Network Health offerings unless otherwise noted in this policy or the applicable Member Handbook. Check the applicable product formulary in the Pharmacy section of our website to determine if the drug requires you to get prior authorization.

For Tufts Health Unify (Medicare-Medicaid One Care for people ages 21 – 64), please refer to Tufts Health Unify Prior Authorization Medical Necessity Guidelines.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines, when applicable, and adherence to plan policies and procedures and claims editing logic.