

**Policy Name:** Eucrisa (crisaborole)

**Policy#:** 2598P

## Purpose of the Policy

The purpose of this policy is to define coverage criteria for Eucrisa (crisaborole).

## Statement of the Policy

Health Alliance Medical Plans and Health Alliance Northwest will approve the use of Eucrisa (crisaborole) under the pharmacy benefit if the following criteria are met.

## Criteria

### 1. Coverage Criteria

- 1.1 Diagnosis of mild to moderate atopic dermatitis
- 1.2 Ordered by a dermatologist (skin doctor)
- 1.3 Documented trial and failure or contraindication to topical corticosteroids
  - Contraindications to topical corticosteroids include:
    - Treatment of sensitive areas (face, anogenital, skin folds)
    - Steroid-induced atrophy
    - Long-term uninterrupted use
- 1.4 Documented trial and failure or contraindication to a topical calcineurin inhibitor (Tacrolimus ointment or Elidel cream)
  - Contraindications to topical calcineurin inhibitors include:
    - Severely impaired skin barrier (Netherton Syndrome)
    - Risk/Presence of malignancy
    - Children < 2 years

### 2. Managed Dose Limit

- 2.1 All topical skin products have a Managed Dose Limit (MDL) in place allowing only the smallest package size of each product to process
- 2.2 Requests for larger package sizes will require documentation of medical necessity, including the following:
  - At least two previous paid claims for the product in the smallest package size within the previous month

### 3. Approval Period

- 3.1 12 months

## CPT Codes

## HCPCS Codes

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## References

1. Eucrisa (crisaborole) [prescribing information]. New York, NY: Pfizer Labs; April 2023.
2. AAAAI/ACAAI JTF Atopic Dermatitis Guideline Panel; Chu DK, Schneider L, Asiniwasis RN, et al. Atopic dermatitis (eczema) guidelines: 2023 American Academy of Allergy, Asthma and Immunology/American College of Allergy, Asthma and Immunology Joint Task Force on Practice Parameters GRADE- and Institute of Medicine-based recommendations. *Ann Allergy Asthma Immunol.* 2024 Mar;132(3):274-312.

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### DISCLAIMER

This Medical Policy has been developed as a guide for determining medical necessity. The process of medical necessity review also entails review of the most recent literature and physician review. Medical Policy is not intended to dictate to providers how to practice medicine. Providers are expected to exercise their medical judgment in providing the most appropriate care. Health Alliance encourages input from providers when developing and implementing medical policies. Benefit determinations are based on applicable contract language in the member's Policy/ Subscription Certificate/ Summary Plan Description. This Medical Policy does not guarantee coverage. There may be a delay between the revision of this policy and the posting on the web. Please contact the Health Alliance Customer Service Department at 1-800-851-3379 for verification of coverage.