BlueCross BlueShield Federal Employee Program

ZYCLARA
(imiquimod)

Pre - PA Allowance

None

Prior-Approval Requirements

Diagnoses

Patient must have **ONE** the following:

1. Actinic keratosis (AK)
   a. 18 years of age or older
   b. **NOT** immunocompromised
   c. Inadequate treatment response, intolerance, or contraindication to **TWO** of the following:
      i. Generic imiquimod
      ii. Fluorouracil
      iii. Diclofenac

2. External genital and perianal warts (EGW)
   a. 12 years of age or older
   b. Inadequate treatment response, intolerance, or contraindication to **TWO** of the following:
      i. Podofilox
      ii. Generic imiquimod
      iii. Cryotherapy

Prior - Approval Limits

Quantity

Actinic keratosis (AK)

Zyclara 2.5% Pump	2 bottles **OR**
Zyclara 3.75% Pump	2 bottles **OR**
Zyclara 3.75% Packets	56 (2 boxes)

External genital and perianal warts (EGW)

Zyclara 3.75% Pump	2 bottles **OR**
Zyclara 3.75% Packets	56 (2 boxes)

Duration 3 months

Prior – Approval *Renewal* Requirements

Diagnoses

Patient must have **ONE** the following:

1. Actinic keratosis (AK)
    a. 18 years of age or older
2. External genital and perianal warts (EGW)
    a. 12 years of age or older

AND ALL of the following:

Re-evaluation of lesion(s) / warts for improvement

Prior - Approval *Renewal* Limits

Quantity

Actinic keratosis (AK)

Zyclara 2.5% Pump	2 bottles **OR**
Zyclara 3.75% Pump	2 bottles **OR**
Zyclara 3.75% Packets	56 (2 boxes)

External genital and perianal warts (EGW)

Zyclara 3.75% Pump	2 bottles **OR**
Zyclara 3.75% Packets	56 (2 boxes)

Duration 3 months (One renewal only)