

# PRIOR AUTHORIZATION CRITERIA

**BRAND NAME**  
(generic)

**EUCRISA**  
(crisaborole)

**Status: CVS Caremark® Criteria**

**Type: Initial Prior Authorization with Quantity Limit**

## POLICY

### FDA-APPROVED INDICATIONS

Eucrisa is indicated for topical treatment of mild to moderate atopic dermatitis in adult and pediatric patients 3 months of age and older.

### COVERAGE CRITERIA

#### **Atopic Dermatitis**

Authorization may be granted when the requested drug is being prescribed for mild to moderate atopic dermatitis when ALL of the following criteria are met:

- The patient is 3 months of age or older
- The patient meets ONE of the following criteria:
  - The patient is less than 2 years of age
  - The requested drug will be used on sensitive skin areas (e.g., face, genitals, or skin folds) and the following criteria is met:
    - The patient experienced an inadequate treatment response, intolerance, or contraindication to a topical calcineurin inhibitor
  - The patient experienced an inadequate treatment response, intolerance, or contraindication to a topical calcineurin inhibitor AND a medium or higher potency topical corticosteroid
- If additional quantities are being requested, then 5 percent or greater body surface area is affected

### CONTINUATION OF THERAPY

#### **Atopic Dermatitis**

Authorization may be granted when the requested drug is being prescribed for mild to moderate atopic dermatitis when ALL of the following criteria are met:

- The patient is 3 months of age or older
- The patient has achieved or maintained a positive clinical response as evidenced by improvement [(e.g., improvement in or resolution of any of the following signs and symptoms: erythema (redness), edema (swelling), xerosis (dry skin), erosions, excoriations (evidence of scratching), oozing and crusting, lichenification (epidermal thickening), OR pruritus (itching)]
- If additional quantities are being requested, then 5 percent or greater body surface area is affected

### QUANTITY LIMITS APPLY

60 grams per 25 days\* or 180 grams per 75 days\*

Greater than 5% BSA: 120 grams per 25 days\* or 360 grams per 75 days\*

\*The duration of 25 days is used for a 30-day fill period and 75 days is used for a 90-day fill period to allow time for refill processing.

### DURATION OF APPROVAL (DOA)

Eucrisa PA with Limit Policy UDR 04-2024.docx

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- 1565-C: Initial therapy DOA: 3 months; Continuation of therapy DOA: 12 months

## **REFERENCES**

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8. Sidbury RS, Alikhan A, Berovitch L, et al. Guidelines of care for the management of atopic dermatitis in adults with topical therapies. *J Am Acad Dermatol*. 2023; 89(1): e1-e20.