STEP THERAPY CRITERIA

BRAND NAME
(generic)

EUCRISA
(crisaborole)

Status: CVS Caremark® Criteria
Type: Initial Step Therapy with Quantity Limit;
Post Step Therapy 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.

INITIAL STEP THERAPY with QUANTITY LIMIT*
**Include Rx and OTC products unless otherwise stated.*

If the patient has filled a prescription for at least a one day supply of a topical calcineurin inhibitor AND a medium or higher potency topical corticosteroid within the past 180 days (see Table 1) under a prescription benefit administered by CVS Caremark, then the requested drug will be paid under that prescription benefit.** If the patient does not meet the initial step therapy criteria, then the claim will reject with a message indicating that a prior authorization (PA) is required. The prior authorization criteria would then be applied to requests submitted for evaluation to the PA unit.

**If the patient meets the initial step therapy criteria, then a quantity limit will apply. If the patient is requesting more than the initial quantity limit, the claim will reject with a message indicating that a PA is required.

INITIAL LIMIT QUANTITY

Drug	**1 Month Limit***	**3 Month Limit***
Eucrisa (crisaborole)	60 grams / 25 days	180 grams / 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.*

TABLE 1: EXAMPLES OF TOPICAL CORTICOSTEROIDS FOR TREATMENT OF ATOPIC DERMATITIS [2,3,4]	
Medium Potency	betamethasone dipropionate lotion, spray 0.05%
	betamethasone valerate cream/lotion 0.1%/foam 0.12%
	clocortolone pivalate cream 0.1%
	desonide lotion, ointment 0.05%
	desoximetasone cream 0.05%
	fluocinolone acetonide cream/ointment/kit 0.025%
	flurandrenolide cream/ointment/lotion 0.05%
	fluticasone propionate cream/lotion 0.05%/ointment 0.005%
	hydrocortisone butyrate cream/lipocream/lotion/ointment/solution 0.1%
	hydrocortisone probutate cream 0.1%
	hydrocortisone valerate cream/ointment 0.2%

	mometasone furoate cream/lotion/solution 0.1%
	prednicarbate cream/ointment 0.1%
	triamcinolone acetonide cream/ointment/lotion/kit 0.1%
	triamcinolone acetonide cream/ointment/lotion 0.025%
	triamcinolone acetonide ointment 0.05%
High Potency	amcinonide cream/ointment/lotion 0.1%
	betamethasone dipropionate cream/ointment 0.05%
	betamethasone dipropionate augmented cream/lotion 0.05%
	betamethasone valerate ointment 0.1%
	desoximetasone cream/ointment/spray 0.25%/gel/ointment 0.05%
	diflorasone diacetate cream (emollient base) 0.05% diflorasone cream 0.05%
	halcinonide cream/ointment 0.1%
	fluocinonide cream/emulsified cream/ointment/gel/solution 0.05%
	mometasone furoate ointment 0.1%
	triamcinolone acetonide aerosol solution 0.147 mg/g
	triamcinolone acetonide cream/ointment 0.5%
Very High Potency	betamethasone dipropionate augmented ointment/gel 0.05%
	clobetasol propionate cream/ointment/foam/shampoo/gel/lotion/solution/spray 0.05%/cream 0.025%
	diflorasone diacetate ointment 0.05%
	flurandrenolide tape 4mcg/cm2
	halobetasol propionate cream/ointment/lotion/kit 0.05%
	fluocinonide cream 0.1%

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)

- 1567-E: Initial therapy DOA: 3 months; Continuation of therapy DOA: 12 months

REFERENCES

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4. 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.
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7. Eichenfield LF, Tom WL, et. al. Guidelines of Care for the Management of Atopic Dermatitis: Section 1. Diagnosis and assessment of atopic dermatitis. *J Am Acad Dermatol* 2014; 70:338-51.
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.