STEP THERAPY CRITERIA

BRAND NAME
(generic)
(oxiconazole) (generic only)

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

POLICY

FDA-APPROVED INDICATIONS
Oxiconazole cream and lotion are indicated for the topical treatment of the following dermal infections: tinea pedis, tinea cruris, and tinea corporis due to *Trichophyton rubrum*, *Trichophyton mentagrophytes*, or *Epidermophyton floccosum*.

Oxiconazole cream is indicated for the topical treatment of tinea (pityriasis) versicolor due to *Malassezia furfur*.

Oxiconazole cream may be used in pediatric patients for tinea corporis, tinea cruris, tinea pedis, and tinea (pityriasis) versicolor; however, these indications for which oxiconazole cream has been shown to be effective rarely occur in children below the age of 12.

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 7 day supply of any of the following GENERIC products: butenafine 1% cream, ciclopirox 0.77% cream, ciclopirox 0.77% gel, ciclopirox 0.77% suspension, clotrimazole 1% cream, clotrimazole 1% solution, econazole 1% cream, ketoconazole 2% cream, ketoconazole 2% shampoo, luliconazole cream, miconazole 2% cream, naftifine cream, terbinafine cream, or tolnaftate 1% cream within the past 120 days 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 the initial limit criteria 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
Limits should accumulate across all drugs and strengths up to highest quantity listed depending on the order the claims are processed. Accumulation does not apply if limit is coded for daily dose.

Drug	1 Month Limit*	3 Month Limit*
oxiconazole cream	60 gm / 25 days	Does Not Apply**
oxiconazole lotion	60 mL / 25 days	Does Not Apply**

** The duration of 25 days is used for a 30-day fill period to allow time for refill processing.*
***** These drugs are for short-term acute use; therefore, the intent is for prescriptions of the requested drug to be filled one month at a time; there should be no 3 month supplies filled.***

COVERAGE CRITERIA

Tinea Corporis, Tinea Cruris, Tinea Pedis, Tinea (pityriasis) Versicolor

Authorization may be granted for the requested drug when ALL of the following criteria are met:

- The requested drug is being prescribed for the treatment of ANY of the following: Tinea pedis, Tinea cruris, Tinea corporis, Tinea (pityriasis) versicolor
- The requested drug is NOT being used in a footbath
- The patient meets ONE of the following:
  - The patient experienced an inadequate treatment response to ANY of the following generic topical antifungals: butenafine cream; ciclopirox cream, gel, suspension; clotrimazole cream, solution; econazole cream; ketoconazole cream, shampoo; luliconazole cream; miconazole cream; naftifine cream; terbinafine cream; or tolnaftate cream
  - The patient experienced an intolerance to ANY of the following generic topical antifungals: butenafine cream; ciclopirox cream, gel, suspension; clotrimazole cream, solution; econazole cream; ketoconazole cream, shampoo; luliconazole cream; miconazole cream; naftifine cream; terbinafine cream; or tolnaftate cream
  - The patient has a contraindication that would prohibit a trial of ANY of the following generic topical antifungals: butenafine cream; ciclopirox cream, gel, suspension; clotrimazole cream, solution; econazole cream; ketoconazole cream, shampoo; luliconazole cream; miconazole cream; naftifine cream; terbinafine cream; or tolnaftate cream

QUANTITY LIMITS APPLY

POST LIMIT QUANTITY

Drug	1 Month Limit*	3 Month Limit*
oxiconazole cream	120 gm / 25 days	Does Not Apply**
oxiconazole lotion	120 mL / 25 days	Does Not Apply**

** The duration of 25 days is used for a 30-day fill period to allow time for refill processing.*
***** These drugs are for short-term acute use; therefore, the intent is for prescriptions of the requested drug to be filled one month at a time; there should be no 3 month supplies filled.***

DURATION OF APPROVAL (DOA)

- 2556-E: DOA: 3 months

REFERENCES

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4. Rotta I, Ziegelmann PK, Otuki MF, Riveros BS, Bernardo NL, Correr CJ. Efficacy of topical antifungals in the treatment of dermatophytosis: a mixed-treatment meta-analysis involving 14 treatments. JAMA Dermatol. 2013;149(3):341-9.
5. Eichenfield L, Tom W, Berger T, 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.
6. U.S. Department of Health & Human Services. Burn Triage and Treatment – Thermal Injuries. Chemical Hazards Emergency Medical Management. February 12, 2024. Available at: https://chemm.hhs.gov/burns.htm. Accessed February 19, 2024.