

# STEP THERAPY CRITERIA

## BRAND NAME (generic)

PRUDOXIN  
(doxepin)

ZONALON  
(doxepin)

**Status: CVS Caremark® Criteria**

**Type: Initial Step Therapy with Quantity Limit;**

**Post Step Therapy Prior Authorization with Quantity Limit**

## POLICY

### FDA-APPROVED INDICATIONS

#### **Prudoxin**

Prudoxin cream is indicated for the short-term (up to 8 days) management of moderate pruritus in adult patients with atopic dermatitis or lichen simplex chronicus.

#### **Zonalon**

Zonalon Cream is indicated for the short-term (up to 8 days) management of moderate pruritus in adult patients with atopic dermatitis or lichen simplex chronicus.

### SCREEN OUT LOGIC 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 a generic topical corticosteroid **AND** at least a 7-day supply of topical tacrolimus ointment or Elidel (pimecrolimus) or Eucrisa (crisaborole) 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 screen out logic, 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 screen out logic, 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.**

<u>Drug</u>	<u>1 Month Limit*</u>	<u>3 Month Limit*</u>
Prudoxin (doxepin)	45 grams / 25 days	Does Not Apply*
Zonalon (doxepin)	45 grams / 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, 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**

### **Pruritus**

Authorization may be granted when the requested drug is being prescribed for the management of moderate pruritus in an adult with atopic dermatitis or lichen simplex chronicus when the following criteria is met:

- The requested drug is being prescribed for short-term use (up to 8 days)

### **QUANTITY LIMITS APPLY**

90 grams per 25 days\*, 3 month limit 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)**

- 2822-E: DOA: 3 months

### **REFERENCES**

1. Prudoxin [package insert]. Newtown, PA: Prestium Pharma, Inc.; June 2017.
2. Zonalon [package insert]. Newtown, PA: Prestium Pharma, Inc.; June 2017.
3. Lexicomp Online, AHFS DI (Adult and Pediatric) Online. Waltham, MA: UpToDate, Inc.; 2024. [https://online.lexi.com.](https://online.lexi.com.;); Accessed February 13, 2024.
4. Micromedex® (electronic version). Merative, Ann Arbor, Michigan, USA. Available at: <https://www.micromedexsolutions.com/> (cited: 02/13/2024).
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. 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.