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Quantity Limit; Post Limit Prior Authorization Mupirocin

Products Referenced by this Document

Drugs that are listed in the following table include both brand and generic and all dosage forms and strengths unless otherwise stated. Over-the-counter (OTC) products are not included unless otherwise stated.

Brand Name	Generic Name	Dosage Form
mupirocin calcium (brand unavailable)	mupirocin calcium	cream
Centany	mupirocin	ointment

Indications

FDA-approved Indications

Mupirocin Calcium Cream

Mupirocin calcium cream is indicated for the treatment of secondarily infected traumatic skin lesions (up to 10 cm in length or 100 cm^2 in area) due to susceptible isolates of Staphylococcus aureus (S. aureus) and Streptococcus pyogenes (S. pyogenes).

Centany Ointment

Centany ointment is indicated for the topical treatment of impetigo due to: Staphylococcus aureus and Streptococcus pyogenes.

Compendial Uses

Complication of catheter – Infectious disease, Exit site; Prophylaxis[5] (Centany only)

Superficial bacterial infection of skin[5]

Initial Quantity Limit

Limits do not accumulate together; patient is allowed the maximum limit for each drug and strength

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 mail limit will be the same as the retail limit. The intent is for prescriptions of the requested drug to be filled one month at a time, even if filled at mail order; there should be no 3-month supplies filled.

If the patient is requesting more than the initial quantity limit, the claim will reject with a message indicating that a prior authorization is required. The prior authorization criteria would then be applied to requests submitted for evaluation to the PA unit.

Drug	**1 Month Limit**	**3 Month Limit**
Mupirocin calcium cream	30 grams / 25 days	Does Not Apply
Centany (mupirocin) ointment	30 grams / 25 days	Does Not Apply

Coverage Criteria

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

- The requested drug is NOT being used in a footbath.
- The requested drug is being prescribed to treat a body surface area that requires more than 30 grams in a one-month period.
- The patient meets ONE of the following:
    - The request is for mupirocin calcium CREAM and the following criteria is met:
        - The requested drug is being prescribed for ANY of the following: treatment of secondarily infected traumatic skin lesions due to susceptible isolates of Staphylococcus aureus or Streptococcus pyogenes, superficial bacterial skin infections.
    - The request is for mupirocin OINTMENT (Centany) and the following criteria is met:
        - The requested drug is being prescribed for ANY of the following: impetigo due to Staphylococcus aureus or Streptococcus pyogenes, superficial bacterial skin infections, prophylaxis of catheter exit-site infections.

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Quantity Limits Apply

60 grams per 25 days

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)

- 2940-HJ: DOA: 1 month

References

1. Mupirocin cream [package insert]. Bedminster, NJ: Alembic Pharmaceuticals, Inc.; December 2023.
2. Centany [package insert]. Fairfield, NJ: Medimetriks Pharmaceuticals, Inc.; June 2015.
3. Mupirocin ointment [package insert]. Mahwah, NJ: Glenmark Pharmaceuticals Inc., USA; August 2021.
4. Lexicomp Online, AHFS DI (Adult and Pediatric) Online. Waltham, MA: UpToDate, Inc.; 2024. https://online.lexi.com. Accessed September 10, 2024.
5. Micromedex (electronic version). Merative, Ann Arbor, Michigan, USA. Available at: https://www.micromedexsolutions.com/ (cited: 09/10/2024).
6. Stevens DL, Bisno AL, Chambers HF, et al. Practice guidelines for the diagnosis and management of skin and soft tissue infections: 2014 Update by the Infectious Diseases Society of America. Clin Infect Dis. 2014;59(2):e10-e52.
7. American Academy of Dermatology Work Group. 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;71:116-132.
8. U.S. Department of Health & Human Services. Burn Triage and Treatment – Thermal Injuries. Available at: https://chemm.hhs.gov/burns.htm. Accessed September 13, 2024.
9. Chow KM, Li PKT, Cho Y, et al. ISPD Catheter-Related Infection Recommendations: 2023 Update. Perit Dial Intl. 2023;43(3):201-219.
10. O'Grady NP, Alexander M, Burns, LA, et al. Guidelines for the Prevention of Intravascular Catheter-Related Infections, 2011. Available at: https://www.cdc.gov/infection-control/hcp/intravascular-catheter-related-infection/?CDC_AAref_Val=https://www.cdc.gov/infectioncontrol/guidelines/bsi/index.html. Accessed September 13, 2024.

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Document History

Written by: UM Development (JK)

Date Written: 04/2019

Revised: (JK) 02/2020 (included compendial use of superficial bacterial skin infections for mupirocin calcium cream), (TM) 12/2020 (no clinical changes); (RZ) 08/2021 (no clinical changes); (MRS) 09/2022 (no clinical changes); (DRS) 09/2023 (no clinical changes); (DFW) 09/2024 (no clinical changes)

Reviewed: Medical Affairs (GAD) 04/2019; (CHART) 02/27/2020, 12/31/2020, 09/30/2021, 09/22/2022, 09/28/2023, 09/26/2024

External Review: 06/2019, 06/2020, 04/2021, 12/2021, 12/2022, 12/2023, 12/2024

CRITERIA FOR APPROVAL

1	Which drug is being requested (applies to brand or generic)? [NOTE: Please check the drug being requested (applies to brand or generic).] [] Mupirocin calcium CREAM (If checked, go to 2) [] Mupirocin OINTMENT (Centany) (If checked, go to 3)		
2	Is the requested drug being prescribed for the any of the following: A) treatment of secondarily infected traumatic skin lesions due to susceptible isolates of Staphylococcus aureus or Streptococcus pyogenes, B) superficial bacterial skin infection? [If Yes, then go to 4. If No, then no further questions.]	Yes	No
3	Is the requested drug being prescribed for any of the following: A) impetigo due to Staphylococcus aureus or Streptococcus pyogenes, B) superficial bacterial skin infection, C) prophylaxis of catheter exit-site infection? [If Yes, then go to 4. If No, then no further questions.]	Yes	No
4	Is the requested drug being used in a footbath? [If Yes, then no further questions. If No, then go to 5.]	Yes	No
5	Is the requested drug being prescribed to treat a body surface area that requires MORE than 30 grams in a one-month period?	Yes	No

[If Yes, then go to 6. If No, then no further questions.]

6	Does the patient require MORE than the plan allowance of 60 grams per month? [No further questions] RPh Note: If yes, then deny and enter a partial approval for 60 grams / 25 days.	Yes	No

Mapping Instructions			
	Yes	**No**	**DENIAL REASONS**
1.	1=2 ;2=3		
2.	Go to 4	Deny	Your plan only covers this drug when it is used for certain health conditions. Covered use is for a skin infection caused by specific bacteria that are susceptible to the requested drug. Your plan does not cover this drug for your health condition that your doctor told us you have. We reviewed the information we had. Your request has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: Diagnosis - cream]
3.	Go to 4	Deny	Your plan only covers this drug when it is used for certain health conditions. Covered uses are for a skin infection caused by specific bacteria that are susceptible to the requested drug or for prevention of an infection around a catheter site. Your plan does not cover this drug for your health condition that your doctor told us you have. We reviewed the information we had. Your request has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: Diagnosis - ointment]

4.	Deny	Go to 5	Your plan only covers this drug if it is not being used in a footbath. We reviewed the information we had. Your request has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: Footbath Use]
5.	Go to 6	Deny	We have denied your request because it is for more than the amount your plan covers (quantity limit). Your plan only covers more of this drug (additional quantities) when you meet the criteria for additional quantities. We reviewed the information we had. We have partially approved your request for this drug up to the amount your plan covers (30 grams per month). Your request for more drug has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: Quantity, Post limit criteria not met, Partial denial]
6.	Deny	[Approve for 1 month. Approve 60 grams per 25 days]. Approve, 1 Months	We have denied your request because it is for more than the amount your plan covers (quantity limit). We reviewed the information we had. We have partially approved your request for this drug up to the amount your plan covers (60 grams per month). Your request for more drug has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: Quantity, Exceeds max limit, Partial denial]