AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name:	Eucrisa	Page:	1 of 2
Effective Date:	8/30/2024	Last Review Date:	7/2024

Applies to:	☒Illinois	☐Florida	☒Florida Kids
	☒New Jersey	☒Maryland	☐Michigan
	☒Pennsylvania Kids	☐Virginia	☐Kentucky PRMD

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Eucrisa under the patient's prescription drug benefit.

Description:

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

Applicable Drug List:

Eucrisa

Policy/Guideline:

The requested drug will be covered with prior authorization when the following criteria are met:

- The requested drug is being prescribed for mild to moderate atopic dermatitis in a patient 3 months of age or older

AND

  - The patient is less than 2 years of age

OR

  - The requested drug will be used on sensitive skin areas (e.g., face, genitals, or skin folds)

AND

  - The patient experienced an inadequate treatment response, intolerance, or contraindication to a topical calcineurin inhibitor

OR

  - The patient experienced an inadequate treatment response, intolerance, or contraindication to a topical calcineurin inhibitor AND a medium or higher potency topical corticosteroid

AND

- If additional quantities are being requested, then 5 percent or greater body surface area is affected

OR

- The request is for continuation of therapy, and the patient achieved or maintained positive clinical response as evidenced by improvement [(e.g., improvement in or resolution of any of the following signs and symptoms: erythema (redness), exudation (oozing and crusting), excoriation (evidence of scratching), induration

(hardening)/papulation (formation of papules), lichenification (epidermal thickening), OR pruritus (itching)]

AND

- If additional quantities are being requested, then 5 percent or greater body surface area is affected

Approval Duration and Quantity Restrictions:

Approval:

- Initial – 3 months
- Renewals – 12 months

Quantity Level Limit:

- 60 gm/25 days* or 180 gm/75 days*
- 120 gm/25* days or 360 gm/75 days* when 5 percent or greater body surface area is affected

**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.*

References:

1. Eucrisa [package insert]. New York, NY: Pfizer Inc.; April 2023.
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3. Micromedex® (electronic version). Merative, Ann Arbor, Michigan, USA. Available at: https://www.micromedexsolutions.com/ (cited: 02/13/2024).
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.
5. Paller AS, Tom WL, et. al. Efficacy and safety of crisaborole ointment, a novel, nonsteroidal phosphodiesterase 4 (PDE4) inhibitor for the topical treatment of atopic dermatitis (AD) in children and adults. *J Am Acad Dermatol.* 2016 Jul 1175(3)494-503.e4.
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 22, 2024.
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.