UnitedHealthcare Community Plan

Clinical Pharmacy Program Guidelines for Eucrisa

Program	Step Therapy
Medication	Eucrisa (crisaborole)
Markets in Scope	Arizona, California, Hawaii, Maryland, Nevada, New Jersey, New York, New York EPP, Pennsylvania- CHIP, Rhode Island, South Carolina
Issue Date	3/2017
Pharmacy and Therapeutics Approval Date	7/2020
Effective Date	9/2020

1. Background:

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

The American Academy of Dermatology guidelines for the care and management of atopic dermatitis recommend topical corticosteroids for patients with atopic dermatitis who have failed to respond to standard non-pharmacologic therapy. They also recommend the use of topical calcineurin inhibitors (tacrolimus, pimecrolimus) in patients who have failed to respond to, or who are not candidates for topical corticosteroid treatment. Eucrisa is not included in the guidelines.

Pimecrolimus (generic Elidel®) is indicated as second-line therapy for the short-term and non-continuous chronic treatment of mild to moderate atopic dermatitis in non-immunocompromised adults and children 2 years of age and older, who have failed to respond adequately to other topical prescription treatments, or when those treatments are not advisable.

Tacrolimus (generic Protopic®) is indicated as second-line therapy for the short-term and non-continuous chronic treatment of moderate to severe atopic dermatitis in non-immunocompromised adults and children, who have failed to respond adequately to other topical prescription treatments for atopic dermatitis or when those treatments are not advisable.

2. Coverage Criteria:

A. Authorization

1. **Eucrisa** will be approved based on **both** of the following criteria:

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a. History of failure, contraindication, or intolerance to one topical corticosteroid [e.g., mometasone furoate, fluocinolone acetonide (generic Synalar), fluocinonide]

-AND-

b. **One** of the following:
(1) Patient is less than 2 years of age

-OR-

(2) History of failure, contraindication, or intolerance to one topical calcineurin inhibitor [e.g., pimecrolimus (generic Elidel), tacrolimus (generic Protopic)]

Authorization will be issued for 12 months.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4. References:

1. Eucrisa [package insert]. Palo Alto, CA: Anacor Pharmaceuticals; March 2020.
2. Elidel [package insert]. Bridgewater, NJ: Valeant Pharmaceuticals August 2014.
3. Protopic [package insert]. Northbrook, IL: Astellas Pharma US, Inc; May 2012.
4. Eichenfield LF, Tom WL, Berger TG, 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(1):116-32.

Program	Step Therapy – Eucrisa
Change Control	
Date	Change
3/2017	New program
10/2017	Removed diagnosis, age, and reauthorization criteria to align with Employer and Individual's step therapy program. Updated background and references.
7/2018	Annual review with no change to coverage criteria. Updated reference.
7/2019	Annual review. Updated references.

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7/2020	Updated step therapy criteria for calcineurin inhibitors to allow for patients who are less than two years of age.

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