UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2020 P 3100-4
Program	Step Therapy
Medication	Eucrisa® (crisaborole)
P&T Approval Date	7/2017, 7/2018, 7/2019, 7/2020
Effective Date	10/1/2020; Oxford only: 10/1/2020

1. Background:

Step therapy programs are utilized to encourage use of lower cost alternatives for certain therapeutic classes. This program requires a member to try one or more preferred topical products before providing coverage for Eucrisa (crisaborole).

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 nonpharmacologic 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.

Patients currently on Eucrisa therapy as documented in claims history will be allowed to continue on their current therapy. For patients with claims history documenting prior use of either topical corticosteroids or topical calcineurin inhibitors, a prescription for Eucrisa will automatically process.

UnitedHealthcare

2. Coverage Criteria[a]:

A. <u>All Diagnoses</u>

1. Eucrisa will be approved based on **<u>one</u>** of the following criteria:

a. History of failure, contraindication, or intolerance to **<u>one</u>** of the following topical therapies:

(a) One topical corticosteroid [e.g., mometasone furoate, fluocinolone acetonide (generic Synalar), fluocinonide]
(b) One topical calcineurin inhibitor [e.g., pimecrolimus (generic Elidel), tacrolimus (generic Protopic)]

-OR-

b. **<u>Both</u>** of the following:

(a) Patient is currently on Eucrisa therapy

-AND-

(b) Patient has **<u>not</u>** received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from the Pfizer sponsored Eucrisa 4 you™ program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of Eucrisa*

*****Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from the Pfizer sponsored Eucrisa 4 you™ program **shall be required** to meet initial authorization criteria as if patient were new to therapy.

Authorization will be issued for 12 months

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

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]. Anacor Pharmaceuticals. Palo Alto, CA. March 2020.
2. Elidel [package insert]. Valeant Pharmaceuticals. Bridgewater, NJ. August 2014.
3. Protopic [package insert]. Astellas Pharma US, Inc. Northbrook, IL 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
7/2017	New program.
7/2018	Annual review with no change to coverage criteria. Updated reference.
7/2019	Annual review with no change to coverage criteria.
7/2020	Changed step from trial of two to trial of one. Updated reference.