

Clinical Policy: Topical Immunomodulators

Reference Number: CP.PMN.107

Effective Date: 09.01.06

Last Review Date: 02.19

Line of Business: Commercial, HIM, Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

The following are topical immunomodulators requiring prior authorization: pimecrolimus (Elidel[®]) and tacrolimus (Protopic[®]).

FDA Approved Indication(s)

Elidel cream is indicated for 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.

Protopic ointment is indicated for 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.

Limitation(s) of use: Protopic ointment and Elidel cream are not indicated for children younger than 2 years of age.

Policy/Criteria

Provider must submit documentation (including such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation[®] that Protopic and Elidel/generics are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Atopic Dermatitis or Vitiligo (must meet all):

1. Diagnosis of atopic dermatitis or vitiligo;
2. If request is for tacrolimus 0.03% ointment or pimecrolimus, member is ≥ 2 years of age;
3. If request is for tacrolimus 0.1% ointment, member is ≥ 16 years of age;
4. Member meets one of the following (a, b, or c):
 - a. Children and adolescents: Failure of 2 medium potency corticosteroids in the previous 6 months, unless contraindicated or clinically significant adverse effects are experienced;
 - b. Adults: Failure of 2 high or very high potency corticosteroids in the previous 6 months, unless contraindicated or clinically significant adverse effects are experienced;

- c. Use on the face or skinfolds;
- 5. Request does not exceed a 30 gm tube per month.

Approval duration:

Medicaid – 6 months

HIM – 12 months

Commercial – Length of Benefit

B. Other diagnoses/indications

- 1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Atopic Dermatitis or Vitiligo (must meet all):

- 1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
- 2. Member is responding positively to therapy;
- 3. If request is for a dose increase, new dose does not exceed a 30 gm tube per month.

Approval duration:

HIM, Medicaid – 12 months

Commercial - Length of Benefit

B. Other diagnoses/indications (must meet 1 or 2):

- 1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.

Approval duration: Duration of request or 12 months (whichever is less); or

- 2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation Key

FDA: Food and Drug Administration

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

CLINICAL POLICY
Topical Immunomodulators

| Drug Name | Dosing Regimen | Dose Limit/ Maximum Dose |
|---|---|--|
| augmented betamethasone 0.05% (Diprolene®) gel | Apply topically to the affected area(s) BID | Should not be used for longer than 2 consecutive weeks |
| clobetasol propionate 0.05% (Temovate®) cream, ointment, gel, solution | | |
| diflorasone diacetate 0.05% (Apexicon®Psorcon®) ointment | | |
| halobetasol propionate 0.05% (Ultravate®) cream, ointment | | |
| augmented betamethasone 0.05% (Diprolene® AF, Diprolene®) cream, ointment, lotion | | |
| diflorasone 0.05% (Apexicon®Psorcon®) cream | | |
| fluocinonide acetone 0.05% cream, ointment, gel, solution | | |
| triamcinolone acetone 0.5% cream, ointment | | |
| desoximetasone 0.25% (Topicort®) cream, ointment | | |
| desoximetasone 0.05% (Topicort®) cream, gel | | |
| fluocinolone acetone 0.025% (Synalar®) cream, ointment | | |
| mometasone 0.1% (Elocon®) cream, ointment, lotion | | |
| triamcinolone acetone 0.025%, 0.1% cream, ointment | | |

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed warnings

- Contraindication(s): hypersensitivity to the active ingredient or any other component of the product
- Boxed warning(s): malignancy

Appendix D: General Information

- On March 10, 2005, the FDA issued a public health advisory about a potential cancer risk from Elidel. The FDA recommends that Elidel should be used second-line, avoided in children below the age of 2, and used in minimum amounts intermittently to control symptoms. Black box warning and Medication Guide for patients have been instituted, as recommended by the FDA.

CLINICAL POLICY
Topical Immunomodulators

- A Consensus Conference on Atopic Dermatitis sponsored by the American Academy of Dermatology recommended that topical immunomodulator agents should be reserved for second line therapy in patients who fail standard interventions, including low to mid potency topical corticosteroids.

V. Dosage and Administration

| Drug | Dosing Regimen | Maximum Dose |
|----------|---|------------------|
| Elidel | A thin layer topically to affected skin BID | 30 gm tube/month |
| Protopic | A thin layer topically to affected skin BID | 30 gm tube/month |

VI. Product Availability

| Drug | Availability |
|----------|-----------------------|
| Elidel | Cream: 1% |
| Protopic | Ointment: 0.03%, 0.1% |

VII. References

1. Elidel Package Insert. Bridgewater, NJ: Valeant Pharmaceuticals North America, LLC, December 2017. Available at <http://www.elidel-us.com>. Accessed November 5, 2018.
2. Protopic Package Insert. Madison, NJ: LEO Pharma Inc., December 2017. Available at <https://www.protopic.com>. Accessed November 5, 2018.
3. 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 Aug; 71(1):116-32.

| Reviews, Revisions, and Approvals | Date | P & T Approval Date |
|---|-------|---------------------|
| Added Protopic to criteria document. Revised the description to create category language (formerly referred only to pimecrolimus). Added references for Protopic. | 02.13 | 02.13 |
| Updated reference section to reflect current literature search. | 02.14 | 02.14 |
| Updated reference section to reflect current literature search. | 02.15 | 02.15 |
| Converted into new policy template; Added that member must be immunocompetent; Added that topical steroid must have been trialed and failed in the last 6 months; Added that disease on the skinfolds could be approved without use of steroid to avoid skin atrophy; Updated reference section to reflect current literature search. | 12.15 | 02.16 |
| Converted to new integrated template; Updated literature search; Removed the following age requirement: Pimecrolimus 1% cream ≥ 2 years of age, because age restrictions are not absolute contraindications per FDA labeling; added positive response to therapy requirement for re-authorization. | 11.16 | 02.17 |

CLINICAL POLICY
Topical Immunomodulators



| Reviews, Revisions, and Approvals | Date | P & T Approval Date |
|---|----------|---------------------|
| 1Q18 annual review: Policy changed from CP.PPA to CP.PMN. Changed authorization duration limits from 3/6 months to 6/12 months. Removed restriction against coverage for vitiligo. References reviewed and updated. | 12.5.17 | 02.18 |
| 1Q 2019 annual review: Policies combined for Commercial (CP.PMN.98), HIM (CP.PMN.98), and Medicaid (CP.PMN.107) lines of business. No significant changes from previously approved corporate policy. Medicaid: per previously approved corporate policy CP.PMN.98 – removed “Member is immunocompetent”, added vitiligo with specific coverage criteria, added age limit for Elidel. References reviewed and updated. | 11.05.18 | 02.19 |

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

CLINICAL POLICY

Topical Immunomodulators

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note:

For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

For Health Insurance Marketplace members, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the non-formulary policy; HIM.PA.103.

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