Pharmacy Drug Policy & Procedure

Policy Name:	Eucrisa (crisaborole)	Policy#:	2598P

Purpose of the Policy

The purpose of this policy is to define coverage criteria for Eucrisa (crisaborole).

Statement of the Policy

Health Alliance Medical Plans will approve the use of Eucrisa (crisaborole) under the pharmacy benefit if the following criteria are met.

Criteria

1. Coverage Criteria

1.1 Diagnosis of mild to moderate atopic dermatitis

1.2 Ordered by a dermatologist (skin doctor)

1.3 Documented trial and failure or contraindication to topical corticosteroids

- Contraindications to topical corticosteroids include:
  - Treatment of sensitive areas (face, anogenital, skin folds)
  - Steroid-induced atrophy
  - Long-term uninterrupted use

1.4 Documented trial and failure or contraindication to a topical calcineurin inhibitor (Tacrolimus ointment or Elidel cream)

- Contraindications to topical calcineurin inhibitors include:
  - Severely impaired skin barrier (Netherton Syndrome)
  - Risk/Presence of malignancy
  - Children < 2 years

2. Managed Dose Limit

2.1 All topical skin products have a Managed Dose Limit (MDL) in place allowing only the smallest package size of each product to process

2.2 Requests for larger package sizes will require documentation of medical necessity, including the following:

- At least two previous paid claims for the product in the smallest package size within the previous month

3. Approval Period

3.1 12 months

CPT Codes	
HCPCS Codes	

References

1. Eucrisa (crisaborole) [prescribing information]. New York, NY: Pfizer Labs; April 2023.
2. AAAAI/ACAAI JTF Atopic Dermatitis Guideline Panel; Chu DK, Schneider L, Asiniwasis RN, et al. Atopic dermatitis (eczema) guidelines: 2023 American Academy of Allergy, Asthma and Immunology/American College of Allergy, Asthma and Immunology Joint Task Force on Practice Parameters GRADE- and Institute of Medicine-based recommendations. Ann Allergy Asthma Immunol. 2024 Mar;132(3):274-312.

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