Health Alliance™

Pharmacy Drug Policy & Procedure

Policy Name:	Atopic Dermatitis Immunomodulator Therapies	Policy #:	3142P

Purpose of the Policy

The purpose of this policy is to define the criteria for coverage of biological therapies used in the treatment of atopic dermatitis for new starts of therapy.

Statement of the Policy

Health Alliance Medical Plans will approve the use of biologic atopic dermatitis therapies under the pharmacy benefit when the following criteria have been met:

Criteria

1. **Coverage Criteria of Preferred Products with Single Step Edit (Dupixent and Adbry)**
   - 1.1 Diagnosis of moderate to severe atopic dermatitis
     - ≥10% of body surface area (BSA)
     - SCORing Atopic Dermatitis (SCORAD) index value of at least 25
   - 1.2 Age ≥6 months (Dupixent) or ≥12 years (Adbry)
   - 1.3 Prescribed by or in consultation with a dermatologist (skin doctor), allergist, or immunologist (doctor specializing in the study of immune systems)
   - 1.4 Documentation of trial, failure, or contraindication to ONE of the following:
     - Topical corticosteroids--acceptable contraindications include treatment of sensitive areas, steroid induced atrophy, long-term uninterrupted use
     - Topical calcineurin inhibitor (tacrolimus ointment or pimecrolimus cream)—acceptable contraindications include severely impaired skin barrier, risk or presence of malignancy
2. **Coverage Criteria of Preferred Products with Double Step Edit (Cibinqo, Rinvoq)**
   - 2.1 Diagnosis of moderate to severe atopic dermatitis
     - ≥10% of body surface area (BSA)
     - SCORing Atopic Dermatitis (SCORAD) index value of at least 25
   - 2.2 Age 12 years or older
   - 2.3 Prescribed by or in consultation with a dermatologist (skin doctor), allergist (allergy doctor), or immunologist (immune system doctor).
   - 2.4 Documentation of trial, failure, or contraindication to ONE of the following:
     - Topical corticosteroids--acceptable contraindications include treatment of sensitive areas, steroid induced atrophy, long-term uninterrupted use
     - Topical calcineurin inhibitor (tacrolimus ointment or pimecrolimus cream)—acceptable contraindications include severely impaired skin barrier, risk or presence of malignancy
   - 2.5 Documentation of minimum 3 month trial, failure, or contraindication to one or more systemic drug product (examples include, but are not limited to Dupixent, Adbry, etc)
3. **Exclusion Criteria**
   - 3.1 Biologics, JAK inhibitors, and immunosuppressants used in combination will not be covered
4. **Approval Period**
   - 4.1 Initial Approval: 12 months
   - 4.2 Subsequent Approvals: 12 months with documentation of positive response to therapy

CPT Codes	

HCPCS Codes	

References

1. 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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