Washington State Health Care Authority

Atopic Dermatitis Agents: Crisaborole (Eucrisa™)

Medical policy no. 90.23.00.AA-3 Effective Date: May 1, 2020

Related medical policies:

- **90.78.40 Atopic Dermatitis Agents – Topical Immunosuppressive**
- **90.27.30 Atopic Dermatitis Agents – Monoclonal Antibodies**
- **90.27.30.AA Atopic Dermatitis Agents- Dupilumab (Dupixent)**

Note: *New-to-market drugs included in this class based on the Apple Health Preferred Drug List are non-preferred and subject to this prior authorization (PA) criteria. Non-preferred agents in this class require an inadequate response or documented intolerance due to severe adverse reaction or contraindication to at least TWO preferred agents. If there is only one preferred agent in the class documentation of inadequate response to ONE preferred agent is needed. If a drug within this policy receives a new indication approved by the Food and Drug Administration (FDA), medical necessity for the new indication will be determined on a case-by-case basis following FDA labeling.*

To see the list of the current Apple Health Preferred Drug List (AHPDL), please visit: https://www.hca.wa.gov/assets/billers-and-providers/apple-health-preferred-drug-list.xlsx

Background:

Atopic dermatitis (AD) is a chronic, non-contagious, inflammatory disease of the skin resulting from a combination of genetic and environmental factors. Often referred to as "eczema," it is characterized by extremely dry, itchy skin typically on the insides of the elbows, behind the knees, and on the face, hands, and feet.

The American Academy of Dermatology guidelines for the care and management of atopic dermatitis recommend the use of topical corticosteroids in patients who have failed to respond to good skin care and regular use of emollients alone. The guidelines recommend using topical calcineurin inhibitors in the following situations: patients refractory to topical corticosteroids, use in sensitive areas (e.g. face, axilla, anogenital region, and skin folds), patients with steroid induced-atrophy, and in patients who require long-term treatment.

Crisaborole (Eucrisa™) is a topical treatment for atopic dermatitis in patients 3 months of age and older. Phosphodiesterase 4 (PDE4) inhibitors are topical drugs that allow cyclic adenosine monophosphate (cAMP) to remain intact in order to decrease the proinflammatory response (e.g., cytokine release) associated with atopic dermatitis.

Medical necessity

Drug	Medical Necessity
crisaborole (Eucrisa™)	Crisaborole may be considered medically necessary in patients who meet the criteria described in the clinical policy below.

Clinical policy:

Drug	**Clinical Criteria (Initial Approval)**
Atopic dermatitis	Crisaborole may be covered when ALL of the following are met: 1. Must be 3 months of age or older; **AND** 2. Diagnosis of atopic dermatitis with documentation of baseline evaluation of the disease, including severity of symptoms; **AND** 3. Trial and failure of at least **TWO** preferred topical corticosteroids (medium or higher potency) for daily treatment for minimum of 28-days within the previous 6 months, unless contraindicated or not tolerated a. Contraindications include: i. Treatment of sensitive areas (face, anogenital, skin folds) not responding to low potency desonide or hydrocortisone; **OR** ii. History of steroid induced atrophy; **OR** iii. Long-term uninterrupted use; **AND** 4. Trial of at least **ONE** topical calcineurin inhibitors (i.e., pimecrolimus, tacrolimus) for minimum of 28-days, unless contraindicated. a. Contraindications include: i. Age less than 2 years of age **If ALL criteria are met, the request may be approved for 6 months** If all criteria are not met, but there are documented medically necessary or situational circumstances, based on the professional judgement of the clinical reviewer, requests may be approved on a case-by-case basis up to the initial authorization duration.
	Criteria (Reauthorization)
	Crisaborole may be reauthorized when ALL of the following are met: **1.** Clinical documentation of disease stability or improvement from baseline. **If ALL criteria are met, the request may be approved for 12 months** If all criteria are not met, but there are documented medically necessary or situational circumstances, based on the professional judgement of the clinical reviewer, requests may be approved on a case-by-case basis up to the reauthorization duration.

Dosage and quantity limits

Drug Name	Dose and Quantity Limits
crisaborole (Eucrisa™)	#1 (60g) tube per 30-days **OR** #1 (100g) tube per 30-days

References

1. Eucrisa Prescribing Information. Pfizer Laboratories. New York, NY. March 2020.
2. Eichenfield LF, Tom WL, Chamlin SL, Feldman SR, Hanifin JM, Simpson EL, et al. Guidelines of care for the management of atopic dermatitis: section 1. Diagnosis and assessment of atopic dermatitis. J Am Acad Dermatol. 2014 Feb;70(2):338-51.
3. Eichenfield LF, Tom WL, Berger TG, Krol A, Paller AS, Schwarzenberger K, 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 Jul;71(1):116-32.
4. Sidbury R, Davis DM, Cohen DE, Cordoro KM, Berger TG, Bergman JN, et al. Guidelines of care for the management of atopic dermatitis: section 3. Management and treatment with phototherapy and systemic agents. J Am Acad Dermatol. 2014 Aug;71(2):327-49.
5. Sidbury R, Tom WL, Bergman JN, Cooper KD, Silverman RA, Berger TG, et al. Guidelines of care for the management of atopic dermatitis: Section 4. Prevention of disease flares and use of adjunctive therapies and approaches. J Am Acad Dermatol. 2014 Dec;71(6):1218-33. Comparison of representative topical corticosteroid preparations. UpToDate. Available at: https://www.uptodate.com/home Accessed December 2017.

History

Date	Action and Summary of Changes
04/18/2018	New Policy
08/21/2019	Updated documentation of baseline evaluation requirement
09/24/2019	General formatting updates
10/11/2019	Clarification on reauthorization criteria 1.
01/02/2020	General grammatical updates
01/13/2020	Changed effective date to May 1, 2020
01/27/2020	Updated contraindications sections to include “not responding to low potency desonide or hydrocorticosne”. Updated footnote date to January 27, 2020.
04/05/2021	Annual policy update. • Updated age to reflect label update • Change corticosteroid trial duration to 28 days • Updated new policy name and number • Updated quantity limits with new 100g size
06/16/2021	Approved by DUR Board