Prior Authorization Criteria

MISSISSIPPI DIVISION OF MEDICAID

PRIOR AUTHORIZATION CRITERIA:

EUCRISA™ (crisaborole) is indicated for topical treatment of mild to moderate atopic dermatitis in adult and pediatric patients 3 months of age and older.

ICD-10 code(s):_____

INITIAL AUTHORIZATION: (will be issued for up to 12 weeks)

EUCRISA will be approved based on **ALL** of the following criteria:

☐ Yes ☐ No Diagnosis of mild to moderate chronic atopic dermatitis (eczema)

AND

☐ Yes ☐ No Age of patient is within age range recommended by FDA label

AND

PATIENTS 3 MONTHS TO <2 YEARS OF AGE:

☐ Yes ☐ No A history of failure (defined as 1 claim in the past 365 days for a minimum of 2 weeks) to at least one claim of ANY topical corticosteroid with steroid potency taken into account based on (1) mild-to-moderate severity of atopic dermatitis and (2) body area where the topical steroid will be applied.

or

☐ Yes ☐ No Contraindication or intolerance to topical steroid.

AND

☐ Yes ☐ No Exacerbating factors that could contribute to the patient's atopic dermatitis have been evaluated and addressed (e.g., non-compliance with therapy, environmental triggers, allergy patch testing, etc.).

OR

PATIENTS 2 YEARS OF AGE AND GREATER:

☐ Yes ☐ No History of failure (1 claim in last 365 days for a minimum of 4 weeks) on **one** of the following:

- Elidel (pimecrolimus) topical cream

or

- tacrolimus (generic Protopic) topical ointment

or

- Contraindication or intolerance of Elidel and tacrolimus

AND

☐ Yes ☐ No For areas other than the face, axillae, anogenital/groin, a history of failure (defined as 1 claim in the past 365 days for a minimum of 2 weeks) to at least one MEDIUM- to HIGH-potency topical corticosteroid

or

☐ Yes ☐ No For sensitive areas (e.g., face, axillae, anogenital/groin) a history of failure (defined as 1 claim in the past 365 days for a minimum of 2 weeks) to at least one claim of ANY topical corticosteroid

or

☐ Yes ☐ No Contraindication or intolerance to topical steroid

AND

☐ Yes ☐ No Exacerbating factors that could contribute to the patient's atopic dermatitis have been evaluated and addressed (e.g., non-compliance with therapy, environmental triggers, allergy patch testing, etc.)

REAUTHORIZATION: (will be issued for up to 52 weeks)

Patient must have the following:

☐ Yes ☐ No Mild to moderate atopic dermatitis (eczema)

AND

☐ Yes ☐ No Positive clinical response to EUCRISA therapy (e.g., reduction in body surface area involvement, reduction in pruritus severity, etc.)

Quantity Limit:

- **EUCRUSA 2% (60 gm or 100 gm tube) 1 tube per 30 days**