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| JOHNS HOPKINS MEDICINE / JOHNS HOPKINS HEALTHCARE | Johns Hopkins HealthCare LLC<br>**Pharmacy Public**<br>**Pharmacy Management Drug Policies** | *Policy Number* | MEDS102 |
| | | *Effective Date* | 04/19/2017 |
| | | *Review Date* | 10/20/2021 |
| | *Subject*<br>**Eucrisa Ointment 2%** | *Revision Date* | 10/20/2021 |
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This document applies to the following Participating Organizations:

Priority Partners

**Keywords**: eucrisa

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## I. POLICY

Eucrisa (crisaborole) Ointment will require prior authorization to ensure appropriate use. The process for initiating a prior authorization request can be found in policy PHARM 20.

- PPMCO members are subject to the Priority Partners formulary, available at www.ppmco.org.
- USFHP members are subject to prior authorization criteria, step-edits and days-supply limits outlined in the Tricare Policy Manual. Tricare Policy supersedes JHHC Medical/Pharmacy Policies. Tricare limits may be accessed at: http://pec.ha.osd.mil/formulary_search.php?submenuheader=1

## II. POLICY CRITERIA

A. **Eucrisa Ointment** may be approved for patients who meet ALL the following criteria:
   1. Patient is 3 months of age or older
   2. Diagnosis of mild to moderate atopic dermatitis affecting greater than or equal to 5% of body surface area
   3. Documentation has been provided showing a baseline assessment using one of the following tools:
      a. Investigator's Static Global Assessment (ISGA) score
      b. Eczema Area and Severity Index (EASI)
      c. Patient-Oriented Eczema Measure (POEM)
      d. Scoring Atopic Dermatitis (SCORAD) index
   4. Documentation showing trial and failure with one or more formulary topical corticosteroids
   5. Documentation showing trial and failure with one topical calcineurin inhibitor [ex. Elidel or Protopic]
      a. *Use of a topical calcineurin inhibitor is not required for patients under 2 years of age

## III. AUTHORIZATION PERIOD/LIMITATIONS

A. Initial approval may be granted for up to 6 months of therapy.
B. Continuation of therapy may be approved in 12-month intervals with documentation showing a clinical improvement as a result of treatment, evidenced by a score reduction in ONE of the following evaluation tools:
   1. ISGA: decrease from baseline by at least 2 points
   2. EASI: decrease from baseline by at least 75%

3. POEM: decrease from baseline by at least 3 points
4. SCORAD: decrease from baseline by at least 50%

C. Limitation: Eucrisa Ointment is limited to one 60-gram tube per month. Requests for higher quantity (such as necessary for a large affected surface area) will be reviewed on a case-by-case basis.

## IV. EXCLUSIONS

A. Eucrisa Ointment will not be approved for the following:
1. Pediatric patients below the age of 3 months
2. Experimental or Investigative uses, including but not limited to the following indications which are not FDA-approved:
   a. Acne Vulgaris
   b. Contact dermatitis
   c. Lichen planus
   d. Lichen sclerosis
   e. Psoriasis
   f. Rosacea
   g. Scabies
   h. Seborrheic dermatitis

B. The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.

## V. REFERENCES

1. Eucrisa Ointment. Prescribing Information. Palo Alto, CA; Anacor Pharmaceuticals, Inc. March 2020.
2. 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 Jul;71(1):116-32.
3. Paller AS, Tom WL, Lebwohl MG et al. Efficacy and safety of crisaborole ointment, a novel, nonsteroidal phosphodiesterase 4 (PDE4) inhibitor for the topical treatment of atopic dermatitis (AD) in children and adults. J Am Acad Dermatol. 2016 Sep;75(3):494-503.

## VI. APPROVALS

Signature on file at JHHC

| DATE OF REVISION | SUMMARY OF CHANGE |
|---|---|
| 04/19/2017 | New Policy creation |
| 07/27/2017 | Updated Exclusions policy regarding physician samples |
| 07/01/2018 | Removed EHP Line of Business |
| 05/05/2020 | Updated approvable age range based on revised FDA-approved prescribing information |
| 04/21/2021 | Clarified clinical criteria for patients under the age of 2 years old |

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| 10/20/2021 | Updated clinical criteria to include use of objective evaluation tools |

Revision Date: 04/19/2017, 07/27/2017, 07/01/2018, 05/05/2020, 04/21/2021, 10/20/2021

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