

Topical Doxepin 5% Cream
Effective 01/01/2023

Plan	<input type="checkbox"/> MassHealth UPPL <input checked="" type="checkbox"/> Commercial/Exchange	Program Type	<input type="checkbox"/> Prior Authorization <input type="checkbox"/> Quantity Limit <input checked="" type="checkbox"/> Step Therapy
Benefit	<input checked="" type="checkbox"/> Pharmacy Benefit <input type="checkbox"/> Medical Benefit		
Specialty Limitations	N/A		
Contact Information	Medical and Specialty Medications		
	All Plans	Phone: 877-519-1908	Fax: 855-540-3693
Exceptions	Non-Specialty Medications		
	All Plans	Phone: 800-711-4555	Fax: 844-403-1029

Overview

Prescriptions that meet the initial step therapy requirements will adjudicate automatically at the point of sale. If the prescription does not meet the initial step therapy requirements, the prescription will deny with a message indicating that prior authorization (PA) is required. Refer to the criteria below and submit a PA request for the members who do not meet the initial step therapy requirements at the point of sale.

Initial Step-Therapy Requirements:

First-Line: Medications listed on first-line are covered without prior-authorization.

Second-Line: Second-line medications will pay if the member has had a 14-day fill of at least two (2) different first-line medications or a second-line medication within the past 180 days.

Coverage Guidelines

If a member does not meet the initial step therapy requirements, then approval of a second-line medication will be granted if the member has had a documented inadequate response or side effect to at least two different 1st-line therapies

FIRST-LINE*	SECOND-LINE
Capsaicin cream Lidocaine patch Super potent topical steroids Betamethasone dipropionate, augmented 0.05% (gel, lotion, ointment) Clobetasol propionate 0.05% (cream, foam, gel, ointment, solution) Fluocinonide 0.1% cream Flurandrenolide 4mcg/cm tape Halobetasol propionate 0.05% (cream, lotion, ointment)	Doxepin 5% Cream

FIRST-LINE*	SECOND-LINE
<p>Potent topical corticosteroids</p> <p>Amcinonide 0.1% cream Betamethasone dipropionate 0.05% cream Betamethasone valerate 0.1% ointment & foam 0.12% Desoximetasone 0.05% cream Diflorasone diacetate 0.05% cream & ointment Fluocinonide 0.05% cream, gel, ointment and solution Fluticasone propionate 0.005% ointment Halcinonide 0.1% cream & ointment Halobetasol propionate 0.01% lotion Mometasone furoate 0.1% ointment Triamcinolone acetonide 0.5% cream & ointment</p> <p>Pimecrolimus Tacrolimus</p>	

*Please note: Some first-line agents require a PA. Please refer to the Drug Look Up tool for coverage.

Limitations

1. A quantity limit of 45 grams per 30 days applies.

References

1. Gooding SM, Canter PH, Coelho HF, et al. Systematic review of topical capsaicin in the treatment of pruritus. *Int J Dermatol* 2010; 49:858
2. Ständer S, Schürmeyer-Horst F, Luger TA, Weisshaar E. Treatment of pruritic diseases with topical calcineurin inhibitors. *Ther Clin Risk Manag* 2006; 2:213
3. Dunford PJ, Williams KN, Desai PJ, et al. Histamine H4 receptor antagonists are superior to traditional antihistamines in the attenuation of experimental pruritus. *J Allergy Clin Immunol* 2007; 119:176
4. Greene SL, Reed CE, Schroeter AL. Double-blind crossover study comparing doxepin with diphenhydramine for the treatment of chronic urticaria. *J Am Acad Dermatol* 1985; 12:669
5. Yosipovitch G, Bernhard JD. Clinical practice. Chronic pruritus. *N Engl J Med* 2013; 368:1625

Review History

11/20/2019 – Reviewed at P&T

11/18/2020- Reviewed at P&T

09/21/2022 – Reviewed at Sept P&T; Separated Comm/Exch vs MH policies; no clinical updates. Effective 01/01/2023

