Mass General Brigham
Health Plan

Eucrisa (crisaberole)
Opzelura (ruxolitinib)
Effective 01/01/2024

Plan	☐ MassHealth UPPL ☒Commercial/Exchange	**Program Type**	☒ Prior Authorization ☐ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☐ Medical Benefit		
Specialty Limitations	N/A		
Contact Information	**Medical and Specialty Medications** All Plans | Phone: 877-519-1908 | Fax: 855-540-3693		
	Non-Specialty Medications All Plans | Phone: 800-711-4555 | Fax: 844-403-1029		
Exceptions	N/A		

Overview
Crisaborole is a topical phosphodieterease-4 (PDE-4) inhibitor indicated for treatment of mild to moderate atopic dermatitis in adults and pediatric patients at least 3 months of age.

Opzelura is indicated for the topical short-term and non-continuous chronic treatment of mild to moderate atopic dermatitis in non-immunocompromised patients 12 years of age and older whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable.

Coverage Guidelines
Authorization may be granted for members new to the plan who are currently receiving treatment with the requested medication excluding when the product is obtained as samples or via manufacturer's patient assistance programs.
OR
Authorization may be granted for members when ALL the following criteria are met, and documentation is provided:

Eucrisa
1. The member is diagnosed with mild to moderate atopic dermatitis
2. The member is at least 3 months old
3. The member meets ONE of the following:
    a. The member has experienced an inadequate response or intolerance to a medium or higher potency topical corticosteroid or a topical calcineurin inhibitor
    b. The member has a contraindication to both topical corticosteroids and topical calcineurin inhibitors

Opzelura
Atopic Dermatitis
1. The drug is being used for topical short-term and non-continuous chronic treatment of mild to moderate atopic dermatitis

2. Physician attestation that atopic dermatitis is limited to no more than 20% body surface area (BSA)
3. The member is 12 years of age or older
4. The member meets ONE of the following:
    a. The member is using medication on a sensitive skin area (e.g., face, genitals, or skin folds) AND has inadequate response, intolerance, or contraindication to a topical calcineurin inhibitor (e.g., tacrolimus or pimecrolimus)
    b. The member has inadequate response, intolerance, or contraindication to a topical calcineurin inhibitor (e.g., tacrolimus or pimecrolimus) AND a medium or high potency topical corticosteroid (see Appendix A)
5. The member has inadequate response, intolerance, or contraindication to Eucrisa (crisaberole)

Vitiligo

1. The drug is being used for nonsegmental vitiligo
2. The member is 12 years of age or older
3. Provider documents ONE of the following:
    a. Inadequate response or adverse reaction to at least TWO medications from the following categories: corticosteroids, topical calcineurin inhibitors
    b. Contraindication to all of the following: corticosteroids, topical calcineurin inhibitors.

Continuation of Therapy

Reauthorizations requires physician documentation of continuation of therapy and maintained positive response to therapy as evidenced by improvement [e.g., improvement in or resolution of any of the following signs and symptoms: erythema (redness), exudation (oozing and crusting), excoriation (evidence of scratching), induration (hardening)/papulation (formation of papules), lichenification (epidermal thickening), or pruritis (itching)] or improvement in vitiligo

Limitations

1. For Eucrisa: Initial approvals and reauthorizations will be granted for 12 months.
2. For Ozelura:
    a. Initial approvals will be granted for 3 months
    b. Reauthorizations will be granted for 12 months
3. The following quantity limits apply:

Eucrisa	60 gam per 30 days

Appendix

Appendix A: Topical Corticosteroid Reference (not all inclusive)

Very High Potency	**Dosage Form**	**Strength**
augmented betamethasone dipropionate (Diprolene)	Ointment	0.05%
clobetasol propionate (Temovate, Olux)	Cream, Gel, Ointment, Sol, Foam	0.05%
diflorasone diacetate (Psorcon)	Ointment	0.05%
High Potency	**Dosage Form**	**Strength**
amcinonide	Cream, Lotion, Ointment	0.1%
augmented betamethasone dipropionate (Diprolene AF)	Cream	0.05%
Betamethasone dipropionate	Cream, Ointment	0.05%
Betamethasone valerate	Ointment	0.1%
Desoximetasone (Topicort)	Cream, Ointment	0.25%
Desoximetasone (Topicort)	Cream, Gel	0.05%

diflorasone diacetate (Psorcon)	Cream	0.05%
Fluocinonide	Cream, Gel, Ointment, Solution	0.05%
Fluocinonide emollient base	Cream	0.05%
Triamcinolone acetonide (Kenalog)	Cream, Ointment	0.5%
Medium Potency	**Dosage Form**	**Strength**
Betamethasone dipropionate (Diprosone)	Lotion	0.05%
Betamethasone valerate	Cream, Lotion	0.1%
Desoximetasone (Topicort LP)	Cream	0.05%
Fluocinolone acetonide (Synalar)	Cream, Ointment	0.025%
Hydrocortisone valerate	Cream, Ointment	0.2%
Mometasone furoate (Elocon)	Ointment	0.1%
Triamcinolone acetonide (Kenalog)	Cream, Lotion, Ointment	0.025%
Triamcinolone acetonide (Kenalog)	Cream, Lotion, Ointment	0.1%

References

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Review History

07/21/2021- Reviewed at July P&T; Switched from CVS Standard criteria to custom template.
01/19/2022 – Reviewed and updated for Jan P&T; added new drug Opzelura to criteria. Reauthorization criteria was clarified to include examples of positive response to therapy (improvement in erythema, exudation, excoriation, induration/papulation, lichenification, or pruritis). Effective 03/01/2022.
01/11/2023 – Reviewed and Updated for Jan P&T; added new indication of vitiligo for Opzelura. References updated. Effective 4/1/2023
11/15/2023 – Reviewed and Updated for Nov P&T; Removed TB requirement for Opzelura. Effective 1/1/2024