Mass General Brigham
Health Plan

Eucrisa (crisaberole)
Opzelura (ruxolitinib)
Effective 04/01/2025

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
Eucrisa (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 (ruxolitinib) is a Janus kinase (JAK) inhibitor 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. Note: patients should be advised to apply to affected areas of up to 20% body surface area.
- Topical treatment of nonsegmental vitiligo in adult and pediatric patients 12 years of age and older. Note: patients should be advised to apply to affected areas of up to 10% body surface area.

Coverage Guidelines
Authorization may be granted for members new to the plan within the past 90 days 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

<u>Eucrisa</u>
1. 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 (see Appendix) or a topical calcineurin inhibitor
    b. The member has a contraindication to both topical corticosteroids and topical calcineurin inhibitors

Opzelura

Atopic Dermatitis

1. Requested medication is being used for topical short-term and non-continuous chronic treatment of mild to moderate atopic dermatitis
2. Member is 12 years of age or older
3. Member meets ONE of the following:
    a. Member has experienced an inadequate response or intolerance to a medium or higher potency topical corticosteroid (see Appendix) or a topical calcineurin inhibitor
    b. Member has a contraindication to both topical corticosteroids and topical calcineurin inhibitors

Vitiligo

1. Diagnosis of nonsegmental vitiligo
2. Member is 12 years of age or older
3. Member meets ONE of the following:
    a. Member has experienced an inadequate response or intolerance to at least ONE medication from one of the following categories: corticosteroids, topical calcineurin inhibitors
    b. Contraindication to all of the following: corticosteroids, topical calcineurin inhibitors.

Continuation of Therapy

Requests for reauthorization will be approved when the following criteria are met:

1. **Atopic Dermatitis:** Documentation has been submitted supporting clinical improvement in the member's condition as evidenced by low disease activity (e.g., clear or almost clear skin), or improvement in signs and symptoms of atopic dermatitis (e.g., redness, itching, oozing/crusting).
2. **Vitiligo:** Documentation has been submitted supporting clinical improvement in the member's condition as evidenced by low disease activity or improvement in signs and symptoms (e.g., improvement in depigmentation score).

Limitations

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

Drug Name	Quantity Limit
Eucrisa	60 grams per 30 days

Appendix

Appendix A: Topical Corticosteroid Reference (not all inclusive)

Potency	Drug	Dosage form	Strength
Super-high potency	Augmented betamethasone dipropionate	Ointment, Lotion, Gel	0.05%
	Clobetasol propionate	Cream, Gel, Ointment, Solution, Cream (emollient), Lotion, Shampoo, Foam, Spray	0.05%
	Fluocinonide	Cream	0.1%
	Flurandrenolide	Tape	4 mcg/cm^2
	Halobetasol propionate	Cream, Lotion, Ointment, Foam	0.05%
High potency	Amcinonide	Ointment	0.1%

Potency	Drug	Dosage form	Strength
	Augmented betamethasone dipropionate	Cream	0.05%
	Betamethasone dipropionate	Ointment	0.05%
	Clobetasol propionate	Cream	0.025%
	Desoximetasone	Cream, Ointment, Spray	0.25%
		Gel	0.05%
	Diflorasone diacetate	Ointment, Cream (emollient)	0.05%
	Fluocinonide	Cream, Ointment, Gel, Solution	0.05%
	Halcinonide	Cream, Ointment	0.1%
	Halobetasol propionate	Lotion	0.01%
High potency	Amcinonide	Cream, Lotion	0.1%
	Betamethasone dipropionate	Cream, hydrophilic emollient	0.05%
	Betamethasone valerate	Ointment	0.1%
		Foam	0.12%
	Desoximetasone	Cream, Ointment	0.05%
	Diflorasone diacetate	Cream	0.05%
	Fluocinonide	Cream, aqueous emollient	0.05%
	Fluticasone propionate	Ointment	0.005%
	Mometasone furoate	Ointment	0.1%
	Triamcinolone acetonide	Cream, Ointment	0.5%
Medium potency	Betamethasone dipropionate	Spray	0.05%
	Clocortolone pivalate	Cream	0.1%
	Fluocinolone acetonide	Ointment	0.025%
	Flurandrenolide	Ointment	0.05%
	Hydrocortisone valerate	Ointment	0.2%
	Mometasone furoate	Cream, Lotion, Solution	0.1%
	Triamcinolone acetonide	Cream	0.1%
		Ointment	0.05% and 0.1%
		Aerosol Spray	0.2 mg per 2-second spray

References

1. Eucrisa Ointment 2% (crisaborole) [prescribing information]. New York, NY: Pfizer Labs; April 2023.
2. 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; 75(3):494-503.e4
3. Misery L, Belloni Fortina A, El Hachem M, et al. A position paper on the management of itch and pain in atopic dermatitis from the International Society of Atopic Dermatitis (ISAD)/Oriented Patient-Education Network in Dermatology (OPENED) task force. J Eur Acad Dermatol Venereol 2021; 35:787

4. Sigurgeirsson B, Boznanski A, Todd G, et al. Safety and efficacy of pimecrolimus in atopic dermatitis: a 5-year randomized trial. Pediatrics 2015; 135:597.
5. Eichenfield LF, Call RS, Forsha DW, et al. Long-term safety of crisaborole ointment 2% in children and adults with mild to moderate atopic dermatitis. J Am Acad Dermatol 2017; 77:641.
6. Svensson A, Chambers C, Gånemo A, Mitchell SA. A systematic review of tacrolimus ointment compared with corticosteroids in the treatment of atopic dermatitis. Curr Med Res Opin 2011; 27:1395
7. Li AW, Yin ES, Antaya RJ. Topical Corticosteroid Phobia in Atopic Dermatitis: A Systematic Review. JAMA Dermatol 2017; 153:1036
8. Choi JY, Dawe R, Ibbotson S, et al. Quantitative analysis of topical treatments in atopic dermatitis: unexpectedly low use of emollients and strong correlation of topical corticosteroid use both with depression and concurrent asthma. Br J Dermatol 2020; 182:1017
9. Opzelura (ruxolitinib) [prescribing information]. Wilmington, DE: Incyte Corporation; August 2024.
10. Eichenfield LF, Tom WL, et. al. Guidelines of care for the management of atopic dermatitis: Section 1. Diagnosis and assessment of atopic dermatitis. *J Am Acad Dermatol* 2014; 70:338-51.
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12. Papp K, Szepietowski JC, Kircik L, et. al. Efficacy and safety of ruxolitinib cream for the treatment of atopic dermatitis: Results from 2 phase 3, randomized, double-blind studies. *J Am Acad Dermatol* 2021;85:863-72.

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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
01/08/2025 – Reviewed and updated for January P&T. Updated Opzelura criteria to remove Eucrisa step requirement. Updated Opzelura atopic dermatitis criteria to require step through with either a topical corticosteroid or calcineurin inhibitor and removed Eucrisa step requirement. Removed BSA restriction from Opzelura atopic dermatitis criteria. Streamlined reauthorization criteria language. Effective 04/01/2025.
02/12/2025 – Reviewed and updated for February P&T. Updated Opzelura vitiligo criteria, requiring a single step instead of a double step. Updated initial approval length for Opzelura from 3 months to 12 months. Effective 04/01/2025.
03/12/2025 – Reviewed and updated for March P&T. Administrative update – updated Appendix listing of corticosteroids. Effective 04/01/2025.