Mass General Brigham
Health Plan

Topical Doxepin 5% Cream
Effective 01/01/2023

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 Benefit** **Pharmacy Benefit**	Phone: 833-895-2611 Phone: 800-711-4555	Fax: 888-656-6671 Fax: 844-403-1029
Exceptions	N/A		

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) **Potent topical corticosteroids** Amcinonide 0.1% cream Betamethasone dipropionate 0.05% cream Betamethasone valerate 0.1% ointment & foam 0.12%	Doxepin 5% Cream

FIRST-LINE*	SECOND-LINE
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 Pimecrolimus Tacrolimus	

*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