Original Effective Date: 10/01/2015
Current Effective Date: 07/17/2025
Last P&T Approval/Version: 04/30/2025
Next Review Due By: 04/2026
Policy Number: C8268-A

Eucrisa (crisaborole)

PRODUCTS AFFECTED

Eucrisa (crisaborole)

COVERAGE POLICY

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Coverage Guideline must be read in its entirety to determine coverage eligibility, if any. This Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide Molina Healthcare complete medical rationale when requesting any exceptions to these guidelines.

Documentation Requirements:
Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational, or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.

DIAGNOSIS:
Atopic Dermatitis

REQUIRED MEDICAL INFORMATION:
This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. If a drug within this policy receives an updated FDA label within6 the last 180 days, medical necessity for the member will be reviewed using the updated FDA label information along with state and federal requirements, benefit being administered and formulary preferencing. Coverage will be determined on a case-by case basis until the criteria can be updated through Molina Healthcare, Inc. clinical governance. Additional information may be required on a case-by-case basis to allow for adequate review. When the requested drug product for coverage is dosed by weight, body surface area or other member specific measurement, this data element is required as part of the medical necessity review. The Pharmacy and Therapeutics Committee has determined that the drug benefit shall be a mandatory generic and that generic drugs will be dispensed whenever available.

A. ATOPIC DERMATITIS:
   1. Documented diagnosis of moderate to severe chronic atopic dermatitis (eczema)
      AND

2. Documentation of inadequate response, serious side effects, or contraindication to TWO of the following: topical corticosteroids or preferred/formulary topical calcineurin inhibitor (tacrolimus, pimecrolimus)
   AND
3. Documentation of prescriber baseline assessment of disease activity (e.g., affected BSA, severity of eczematous lesions, pruritis, etc.)

CONTINUATION OF THERAPY:

A. ATOPIC DERMATITIS:

1. Adherence to therapy at least 85% of the time as verified by the prescriber or member medication fill history OR adherence less than 85% of the time due to the need for surgery or treatment of an infection, causing temporary discontinuation
   AND
2. Documentation that member's condition has improved based upon the prescriber's assessment of disease control and clinical improvements while on therapy (e.g., reduction of affected BSA, improvements in severity of eczematous lesions, decrease in pruritus severity, etc.)
   AND
3. Prescriber attests to or clinical reviewer has found no evidence of intolerable adverse effects or drug toxicity

DURATION OF APPROVAL:

Initial authorization: 6 months, Continuation of Therapy: 12 months

PRESCRIBER REQUIREMENTS:

None

AGE RESTRICTIONS:

3 months of age and older

QUANTITY:

60g per 30 days or 120g per 30 days when 5% or greater body surface area is affected. [Provider must submit documentation to support greater than 120 gram approval]

PLACE OF ADMINISTRATION:

The recommendation is that topical medications in this policy will be for pharmacy benefit coverage and patient self-administered.

DRUG INFORMATION

ROUTE OF ADMINISTRATION:

Topical

DRUG CLASS:

Phosphodiesterase 4 (PDE 4) Inhibitors-Topical

FDA-APPROVED USES:

Indicated for topical treatment of mild to moderate atopic dermatitis in adult and pediatric patients 3 months of age and older.

COMPENDIAL APPROVED OFF-LABELED USES:

None

APPENDIX

APPENDIX 1:

Very High Potency
Betamethasone dipropionate (augmented)
Clobetasol
Diflorasone diacetate ointment
Halobetasol

High Potency
Amcinonide
Betamethasone dipropionate
Desoximetasone gel, ointment, or cream 0.25% or more
Diflorasone diacetate cream
Fluocinolone cream 0.2% or more
Fluocinonide
Halcinonide
Triamcinolone 0.5% or more

Medium Potency
Beclomethasone
Betamethasone benzoate
Betamethasone valerate
Hydrocortisone acetate
Clobetasone
Clocortolone
Desoximetasone cream less than 0.25%
Diflucortolone
Fluocinolone ointment or topical solution or cream less than 0.2%
Flurandrenolide 0.025% or more
Fluticasone Hydrocortisone butyrate
Hydrocortisone valerate
Mometasone Prednicarbate
Triamcinolone less than 0.5%

Low Potency
Alclometasone
Desonide Dexamethasone
Flumethasone
Flurandrenolide less than 0.025%
Hydrocortisone base

BACKGROUND AND OTHER CONSIDERATIONS

BACKGROUND:
The American Academy of Dermatology guidelines for the care and management of atopic dermatitis recommend topical corticosteroids for patients with atopic dermatitis who have failed to respond to standard nonpharmacologic therapy. They also recommend the use of topical calcineurin inhibitors (tacrolimus, pimecrolimus) in patients who have failed to respond to, or who are not candidates for topical corticosteroid treatment.

CONTRAINDICATIONS/EXCLUSIONS/DISCONTINUATION:
All other uses of Eucrisa (crisaborole) are considered experimental/investigational and therefore, will follow Molina's Off-Label policy.
Contraindications to Eucrisa (crisaborole) include: known hypersensitivity to crisaborole or any component of the formulation.

OTHER SPECIAL CONSIDERATIONS:
None

CODING/BILLING INFORMATION

CODING DISCLAIMER. *Codes listed in this policy are for reference purposes only and may not be all-inclusive or applicable for every state or line of business. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does not guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry-standard coding practices for all submissions. Molina has the right to reject/deny the claim and recover claim payment(s) if it is determined it is not billed appropriately or not a covered benefit. Molina reserves the right to revise this policy as needed.*

HCPCS CODE	DESCRIPTION
NA	

AVAILABLE DOSAGE FORMS:
Eucrisa OINT 2%

REFERENCES

1. Eucrisa (crisaborole) ointment, for topical use [prescribing information]. New York, NY: Pfizer Labs; April 2023.
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. JAm Acad Dermatol. 2014; 71(1):116-32.
3. Eichenfield LF, Boguniewicz M, Simpson EL, et al. Translating Atopic Dermatitis Management Guidelines Into Practice for Primary Care Providers. *Pediatrics.*2015;136(3):554-565.
4. Sidbury R, Alikhan A, Bercovitch L, Cohen DE, Darr JM, Drucker AM, Eichenfield LF, Frazer- Green L, Paller AS, Schwarzenberger K, Silverberg JI, Singh AM, Wu PA, Davis DMR, Guidelines of care for the management of atopic dermatitis in adults with topical therapies, Journal of the American Academy of Dermatology (2023), doi: https://doi.org/10.1016/j.jaad.2022.12.029.

SUMMARY OF REVIEW/REVISIONS	DATE
REVISION-Notable revisions: Title Diagnosis Required Medical Information Continuation of Therapy Duration of Approval Age Restrictions Quantity FDA Approved Uses Compendial Approved Off-Labeled Uses Appendix Contraindications/Exclusions/Discontinuation References	Q2 2025

REVISION-Notable revisions: Required Medical Information Appendix References	Q2 2024
REVISION-Notable revisions: Required Medical Information Continuation of Therapy Quantity FDA-Approved Uses Appendix Contraindications/Exclusions/Discontinuation References	Q2 2023
REVISION-Notable revisions: FDA Approved Uses References	Q2 2022
Q2 2022 Established tracking in new format	Historical changes on file