MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association

Pharmacy Medical Policy

Immunomodulators for Skin Conditions

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Policy Number: 010

BCBSA Reference Number: None

Related Policies

Rinvoq: Policy 049
Dupixent: Policy 033

Policy

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

Note: All requests for outpatient retail pharmacy for indications listed and not listed on the medical policy guidelines may be submitted to BCBSMA Clinical Pharmacy Operations by completing the Prior Authorization Form on the last page of this document. Physicians may also call BCBSMA Pharmacy Operations department at (800)366-7778 to request a prior authorization/formulary exception verbally. Patients must have pharmacy benefits under their subscriber certificates.

Please refer to the chart below for the formulary status of the medications affected by this policy.

Drug-Topical Atopic Dermatitis	**Formulary Information**
	Standard
	Formulary Status
Step 1	
Topical Corticosteroid	Covered
Step 2	
Opzelura ™ (ruxolitinib)	Prior use of Step 1 Required
Pimecrolimus Topical	
Tacrolimus Topical	

Step 3	
Elidel ® (pimecrolimus)	Requires prior use of two step 2 medications
Eucrisa ®* (crisaborole)	
Protopic ® (tacrolimus)	

*Non formulary medications are covered when a formulary exception request is submitted to BCBSMA Pharmacy Operations and step criteria below are met.

Drug-Topical Psoriasis	**Formulary Information**
	Standard
	Formulary Status
Step 1	
Topical Corticosteroid	Covered
calcipotriene	Covered
calcipotriene - betamethasone	Covered
calcipotriene - clobetasol	Covered
Step 2	
Vtama ™ (tapinarof)	Prior use of two (2) Step one medications Required

*Non formulary medications are covered when a formulary exception request is submitted to BCBSMA Pharmacy Operations and step criteria below are met.

Drug-Systemic	**Formulary Information**
	Standard
	Formulary Status
Step 1	
Dupixent ®(dupilumab)	PA Required - Dupixent Policy Criteria in Policy 033
Rinvoq ® (upadacitinib)	PA Required (see below)
Step 2	
Adbry ™(tralokinumab)	Prior use of Step 1 Required
Step 3	
Cibinqo ™ (abrocitinib)	Requires prior use of two step 2 medications if available

*Non formulary medications are covered when a formulary exception request is submitted to BCBSMA Pharmacy Operations and step criteria below are met.

Step Criteria:

We may cover the following Immunologic medications listed in the chart above for new starts* in the following stepped approach:

*New start is defined as no previous paid claim for the requested medication within the past 130 days.

Step 1 -: Formulary step 1 medications will be covered as designated in the status table above

Step 2 -: Formulary step 2 medications may be covered when one of the following criteria is met:
• There must be evidence of a BCBSMA paid claim of a Step 1 drug within the previous 130 days or previous treatment.
OR
• There must be evidence of a BCBSMA paid claim by the patient of a Step 2 drug within the previous 130 days or previous treatment.

Step 3 -: Non- Formulary step 3 medications may be covered when the following criteria is met:
• There must be evidence of BCBSMA paid claims by the patient of two different Step 2 drugs if available within the previous 130 days or previous treatment.
OR
• There must be evidence of a BCBSMA paid claim by the patient of a Step 3 drug within the previous 130 days or previous treatment. If the Medication is Not Covered/Non-formulary the drug needs to meet requirements for a Formulary Exception for continued coverage.

Prior Authorization Criteria:

We may cover Rinvoq ® (upadacitinib) for the treatment of adults and pediatric patients 12 years of age and older with refractory, moderate to severe atopic dermatitis whose disease is not adequately controlled with other systemic drug products, including biologics, or when use of other systemic drug products, including biologics, or when use of those therapies are inadvisable when **ALL** of the following criteria must be met:

- The patient has moderate-to-severe atopic dermatitis (eczema),

And

- The patient is 12 years old or older,

And

- Patient has inadequate response to at least ONE other systemic drug including biologics, or when other systemic drugs are contraindicated

And

- The medication is prescribed by or in consultation with an allergist, immunologist, or dermatologist.

Note: If approved the Prior Authorization/ Step Therapy will be granted for up to one (1) year. We do not cover the above drugs for other conditions not listed above.

**Requests based exclusively on the use of samples will not meet coverage criteria for exception. Additional clinical information demonstrating medical necessity of the desired medication must be submitted by the requesting prescriber for review.

Individual Consideration

All our medical policies are written for the majority of people with a given condition. Each policy is based on medical science. For many of our medical policies, each individual's unique clinical circumstances may be considered in light of current scientific literature. For example, high-potency Steroids are not recommended to be applied to the face or groin because they can cause thinning of the skin. Physicians may send relevant clinical information for individual patients for consideration to:

Blue Cross Blue Shield of Massachusetts
Pharmacy Operations Department
25 Technology Place
Hingham, MA 02043
Tel: 1-800-366-7778
Fax: 1-800-583-6289

Prior Authorization Information

Outpatient

For services described in this policy, see below for products where prior authorization **IS REQUIRED** if the procedure is performed **outpatient**.

	Outpatient
Commercial Managed Care (HMO and POS)	Prior authorization is **required**.
Commercial PPO and Indemnity	Prior authorization is **required**.

Policy History

Date	Action
8/2022	Updated to add New Table for Topical psoriasis and add Vtama to the policy.
5/2022	Updated to include PA criteria for Rinvoq.
4/2022	Updated to consolidate the Biologicals for Atopic Dermatitis into this policy and updated Opzelura ™ to step 2 of the policy
1/2022	Updated to add Opzelura ™ to step 3 of the policy.
4/2020	Updated to remove age edits
1/2019	Updated Cortico-steroid trial time to 2 weeks & Add Generic Elidel® to step 2.
11/2018	Moved Dupixent® to policy 033.
11/2017	Updated to include Dupixent® as step 3 to the policy.
6/2017	Updated address for Pharmacy Operations.
1/2014	Updated ExpressPAth language and remove Blue Value.
11/2011-4/2012	Medical policy ICD 10 remediation: Formatting, editing and coding updates. No changes to policy statements.
11/2011	Reviewed - Medical Policy Group - Plastic Surgery and Dermatology. No changes to policy statements.
5/2011	Reviewed - Medical Policy Group - Pediatrics and Endocrinology. No changes to policy statements.
12/2010	Reviewed - Medical Policy Group - Plastic Surgery and Dermatology. No changes to policy statements.
5/2010	Reviewed - Medical Policy Group - Pediatrics and Endocrinology. No changes to policy statements.
12/2009	Reviewed - Medical Policy Group - Plastic Surgery and Dermatology.

	No changes to policy statements.
5/2009	Reviewed - Medical Policy Group - Pediatrics and Endocrinology. No changes to policy statements.
12/2008	Reviewed - Medical Policy Group - Plastic Surgery and Dermatology. No changes to policy statements.
5/2008	Reviewed - Medical Policy Group - Pediatrics and Endocrinology. No changes to policy statements.
12/2007	Reviewed - Medical Policy Group - Plastic Surgery and Dermatology. No changes to policy statements.
5/2007	Reviewed - Medical Policy Group - Pediatrics and Endocrinology. No changes to policy statements.
8/2002	New policy, effective 8/2002, describing covered and non-covered indications.

Endnotes and References

1. Based on the recommendation of the BCBSMA Pharmacy and Therapeutics Committee, 2/2002 and updated on P&T recommendations 12/2002.
2. Based on the recommendation of the BCBSMA Pharmacy and Therapeutics Committee and FDA approved indications updated on 5/2005.

To request prior authorization using the Massachusetts Standard Form for Medication Prior Authorization Requests (eForm), click the link below:
http://www.bluecrossma.org/medical-policies/sites/g/files/csphws2091/files/acquiadam-assets/023%20E%20Form%20medication%20prior%20auth%20instruction%20prn.pdf