New Hampshire Medicaid Fee-for-Service Program

Atopic Dermatitis Criteria

Approval Date: August 7, 2020

Medications

Brand Names	Generic Names	Dosage
Elidel®	pimecrolimus	1% cream
Eucrisa®	crisaborole	2% ointment
Protopic®	tacrolimus	0.03%, 0.1% ointment

For requests for dupilumab **(Dupixent®) use the Dupixent® criteria**

Criteria for Approval

1. FDA-approved indication and age:
   a. **Eucrisa® (crisaborole):** Topical treatment of mild to moderate atopic dermatitis in patients ≥2 years old
   b. **Elidel® (pimecrolimus):** Second-line therapy for the short-term and non-continuous chronic treatment of mild to moderate atopic dermatitis in non-immunocompromised adults and children ≥2 years old who have failed to respond adequately to other topical prescription treatments or when those treatments are not advisable
   c. **Protopic® (tacrolimus):** Second-line therapy for the short-term and non-continuous chronic treatment of moderate to severe atopic dermatitis in non-immunocompromised adults and children who have failed to respond adequately to other topical prescription treatments for atopic dermatitis or when those treatments are not advisable
      i. 0.03% ointment approved for patients 2–15 years old
      ii. 0.03% ointment and 0.1% ointment approved for adults; **AND**

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2. Patient has a defined failure or contraindication or intolerance to a trial of topical corticosteroids. In general, a trial constitutes two weeks for high-potency topical corticosteroids (e.g., diflorasone diacetate) and four weeks for low-potency topical corticosteroids (e.g., hydrocortisone acetate); **AND**
3. Prescribed utilization is for short-term (up to six consecutive weeks at a time) therapy or for non-continuous intermittent therapy (up to one year in duration).

Length of Approval: Two months

Renewal: Six months

Criteria for Denial

1. Failure to meet criteria for approval; **OR**
2. Treatment of psoriasis; **OR**
3. Treatment of infected atopic dermatitis; **OR**
4. Treatment of Netherton's Syndrome.

References

Available upon request.

Revision History

Reviewed by	Reason for Review	Date Approved
Pharmacy & Therapeutic Committee	New	11/02/2006
Commissioner	New	11/16/2006
DUR Board	Review	10/25/2010
Commissioner	Approval	02/10/2011
DUR Board	Revision	10/24/2017
Commissioner	Approval	12/05/2017
DUR Board	Revision	03/12/2019
Commissioner Designee	Approval	04/05/2019
DUR Board	Revision	10/28/2019
Commissioner Designee	Approval	12/03/2019
DUR Board	Revision	06/30/2020
Commissioner Designee	Approval	08/07/2020