



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

None

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. Physicians may also submit requests for retail pharmacy exceptions via the web using Express PA which can be found on the BCBSMA provider portal or directly on the web at <https://provider.express-path.com>. 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	Formulary Information	
	Standard	
	Formulary Status	
Step 1		
Topical Corticosteroid	Covered	
Step 2		
Pimecrolimus Topical	Prior use of Step 1 Required	
Tacrolimus Topical		
Step 3		

Elidel® (pimecrolimus)	Prior use of Step 1 & both Step 2 meds Required
Protopic® (tacrolimus)	

We may cover **Pimecrolimus** Topical or **Tacrolimus** Topical for the FDA approved indication of atopic dermatitis or eczema when **ALL** of the following criteria are met^{1,2}:

- Member is ≥ 2 years of age

AND

- Member has demonstrated treatment failure with a 14-day trial of a prescription topical corticosteroid within the previous 90 days.

We may cover **Protopic®** (tacrolimus) or **Elidel®** (Pimecrolimus) for the FDA approved indication of atopic dermatitis or eczema when **ALL** of the following criteria are met^{1,2}:

- Member is ≥ 2 years of age

AND

- Member has demonstrated treatment failure with a 14-day trial of a prescription topical corticosteroid within the previous 90 days.

AND

- Member has claim history of pimecrolimus topical and tacrolimus topical within the previous 90 days.

Note: Approved prior authorization requests will be limited to 1 year. We do not cover the above drugs for other conditions not listed above.

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

Managed Care Authorization Instructions

- Physicians may call BCBSMA Pharmacy Operations department to request a review for prior authorization for patients who do not meet the step-therapy criteria at the point of sale. Pharmacy Operations: (800)366-7778
- Physicians may also fax or mail the attached form to the address above. The Formulary Exception/Prior Authorization form is included as part of this document for physicians to submit for patients who do not meet the step therapy criteria at the point of sale.
- Physicians may also submit requests for retail pharmacy exceptions via the web using Express PAtH which can be found on the BCBSMA provider portal or directly on the web at <https://provider.express-path.com>.

PPO and Indemnity Authorization Instructions

- Physicians may call BCBSMA Pharmacy Operations department to request a review for prior authorization for patients who do not meet the step-therapy criteria at the point of sale.
.Pharmacy Operations: (800)366-7778
- Physicians may also fax or mail the attached form to the address above. The Formulary Exception/Prior Authorization form is included as part of this document for physicians to submit for patients who do not meet the step therapy criteria at the point of sale.
- Physicians may also submit requests for retail pharmacy exceptions via the web using Express PAtH which can be found on the BCBSMA provider portal or directly on the web at <https://provider.express-path.com>.

Policy History

Date	Action
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

- Based on the recommendation of the BCBSMA Pharmacy and Therapeutics Committee, 2/2002 and updated on P&T recommendations 12/2002.
- 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.com/common/en_US/medical_policies/023%20E%20Form%20medication%20prior%20auth%20instruction%20prn.pdf