

Pharmacy Policy

Topical Medications (Misc)

Policy Number: 9.906

Revision Number: R0

Version Effective Date: 1/1/2021

Product Applicability <input type="checkbox"/> All Plan+ Products	
<p>Well Sense Health Plan</p> <input checked="" type="checkbox"/> New Hampshire Medicaid	<p>Boston Medical Center HealthNet Plan</p> <input type="checkbox"/> MassHealth - MCO <input type="checkbox"/> MassHealth - ACO <input type="checkbox"/> Qualified Health Plans/ConnectorCare/Employer Choice Direct <input type="checkbox"/> Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Prior Authorization Policy

Products Affected:

- Doxepin topical 5%
- Prudoxin topical 5%
- Zonalon topical 5%

The Plan may authorize coverage of the above products for members meeting the following criteria:

Covered Use	All FDA approved indications not otherwise excluded
Exclusion Criteria	None
Required	

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Medical Information	Doxepin topical, Prudoxin topical, Zonalon topical Documentation of the following: <ol style="list-style-type: none"> 1. Diagnosis of pruritus with atopic dermatitis or pruritus with lichen simplex chronicus; AND 2. Inadequate response or intolerance to two of the following: <ol style="list-style-type: none"> a. systemic therapy (eg. antihistamines, oral corticosteroids) b. topical corticosteroid c. topical calcineurin inhibitors
Age Restrictions	18 years of age and older
Prescriber Restriction	None
Coverage Duration	1 tube (45 grams) per year
Quantity Limit	45 grams
Other criteria	Reauthorization criteria: <ol style="list-style-type: none"> 1. Medical necessity for exceeding quantity limits; AND 2. Prescriber attestation that the patient's clinical condition has improved or stabilized with the current therapy with no significant adverse events.

Clinical Background Information and References

1. Bactroban nasal ointment (mupirocin) [prescribing information]. Research Triangle Park, NC: GlaxoSmithKline; May 2017.
2. Harris, Anthony. "Methicillin-resistant Staphylococcus aureus (MRSA) in adults: Prevention and control." UpToDate. Last updated Jul 31,2018. Accessed on Oct 25, 2018.
3. Weston LW, Howe W. Treatment of atopic dermatitis (eczema). Available at UpToDate. Last updated Mar 12, 2019. Accessed April 2019.
4. Fazio SB, Yosipovitch G. Pruritus: Overview of management. Available at UpToDate. Last updated Jan 15, 2019. Accessed April 2019.

Original Approval Date	Original Effective Date	Policy Owner	Approved by
9/10/2020	1/1/2021	Pharmacy Services	Pharmacy & Therapeutics (P&T) Committee, NH DHHS

Policy Revisions History

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Policy Revisions History

Review Date	Summary of Revisions	Revision Effective Date	Approved by
9/10/2020	P&T annual review: 9.111 Topical Medications(Misc) Policy retired, new policy created; Moved amcinonide cream 0.1%, clobetasol Shampoo 0.05%, diflorasone Ointment 0.05% from PA to covered to align with NH PDL requirements; moved Cortisporin cream to NP; removed Bactroban nasal ointment due to product discontinuation	1/1/2021	P&T Committee, NH DHHS

Next Review Date

2021

Reference to Applicable Laws and Regulations, If Any

Disclaimer Information

Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

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