Clinical Policy: Topical Agents: Corticosteroids

Reference Number: OH.PHAR.PPA.92
Effective Date: 01/01/2020 Revision Log
Last Review Date:
Line of Business: Medicaid

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

TOPICAL AGENTS: CORTICOSTEROIDS – LOW POTENCY

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
DESONIDE cream, ointment (generic of Desowen®) FLUOCINOLONE ACETONIDE 0.01% cream, solution (generic of Synalar®) FLUOCINOLONE body oil, scalp oil (generic of Derma-Smoothe/ FS®) HYDROCORTISONE cream, lotion, ointment	ALCLOMETASONE cream, ointment (generic of Aclovate®) CAPEX® shampoo (fluocinolone acetonide) DESONATE®gel (desonide) DESONIDE lotion (generic of Desowen®) HYDROCORTISONE ACETATE WITH ALOE gel HYDROCORTISONE WITH UREA cream (generic of Carmol HC®) PANDEL® cream (hydrocortisone probutate) PEDIADERM HC® kit

TOPICAL AGENTS: CORTICOSTEROIDS – MEDIUM POTENCY

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
BETAMETHASONE DIPROPIONATE-CALCIPOTRIENE Ointment BETAMETHASONE VALERATE cream, lotion (generic of Valisone®) FLUTICASONE PROPIONATE cream, ointment (generic of Cutivate®) MOMETASONE FUROATE cream, ointment, solution (generic of Elocon®) PREDNICARBATE cream (generic of Dermatop®) TRIAMCINOLONE ACETONIDE cream, ointment, lotion (generic of Aristocort®, Kenalog®)	BETAMETHASONE DIPROPIONATE lotion (generic of Diprolene®) CLOCORTOLONE PIVALATE (generic of Cloderm®) CORDRAN® tape (flurandrenolide) DESOXIMETASONE cream, gel, ointment (generic of Topicort®) FLUOCINOLONE ACETONIDE 0.025% cream, ointment (generic of Synalar®) FLUTICASONE PROPIONATE lotion (generic of Cutivate®) HYDROCORTISONE BUTYRATE cream, ointment, solution (generic of Locoid®) HYDROCORTISONE VALERATE cream, ointment (generic of Westcort®) LUXIQ® (betamethasone valerate foam) PREDNICARBATE ointment (generic of Dermatop®)

TOPICAL AGENTS: CORTICOSTEROIDS – HIGH POTENCY

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
AMCINONIDE ointment, cream, lotion BETAMETHASONE VALERATE ointment (generic of Valisone®) DIFLORASONE DIACETATE cream, ointment (generic of Florone®) FLUOCINONIDE cream, gel, ointment, solution (generic of Lidex®, Lidex-E®)	APEXICON-E® (diflorasone diacetate emollient base) cream BETAMETHASONE DIPROPIONATE cream, ointment (generic of Diprolene®) FLUOCINONIDE (generic of Vanos® cream) HALOG® cream, ointment (halcinonide) KENALOG® aerosol spray (triamcinolone acetonide) SERNIVO™ (betamethasone dipropionate spray)

TOPICAL AGENTS: CORTICOSTEROIDS – VERY HIGH POTENCY

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
CLOBETASOL PROPIONATE cream, foam, gel, lotion, ointment, spray, shampoo, solution (generic of Clobex®, Olux®, Temovate®)	BETAMETHASONE DIPROPIONATE AUGMENTED cream, ointment, lotion, gel (generic of Diprolene AF®) BRYHALI™ (halobetasol propionate lotion) CLOBEX® lotion, shampoo,(clobetasol propionate) CLODAN® shampoo, kit (clobetasol propionate) HALOBETASOL PROPIONATE cream, ointment (generic of Ultravate®) LEXETTE™ (halobetasol propionate foam) OLUX-E® foam (clobetasol propionate)

FDA approved indication(s)

The list below may not be all inclusive. Varies by drug product. If needed, please see package insert, clinical pharmacology, or other appropriate clinical reference.

Treatment of inflammatory manifestations of corticosteroid-responsive dermatitis such as:

- alopecia areata
- atopic dermatitis
- contact dermatitis
- exfoliative dermatitis
- *Rhus dermatitis* (due to plants like poison ivy, poison oak, or poison sumac)
- seborrheic dermatitis
- subacute cutaneous and discoid lupus erythematosus
- eczema
- granuloma annulare
- intertrigo
- cutaneous lichen planus

- lichen simplex chronicus
- polymorphous light eruption
- pruritus
- psoriasis
- sarcoidosis
- Stevens-Johnson syndrome
- sunburn
- urticaria
- xerosis (inflammatory phase)

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of Buckeye Health Plan, an affiliate of Centene Corporation® that Topical Agents: Corticosteroids are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

1. Prescribed indication is FDA-approved or supported by standard pharmacopeias;
2. Member must meet labeled age requirements for the medication;
3. Failure of two medications not requiring prior approval, each for ≥ 14 days, unless member meets one of the following (a, b, or c):
   a. Allergy to at least two medications not requiring prior approval;
   b. Contraindication to all medications not requiring prior approval;
   c. History of unacceptable/toxic side effects to at least two medications not requiring prior approval.

   Approval Duration:
   Low and Medium Potency - 12 months
   High and Very High Potency – 90 days

II. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off-label use policy - CP.PMN.53 or evidence of coverage documents.

III. Appendices/General Information

Appendix A: Abbreviation Key
FDA: Food and Drug Administration

Appendix B: Therapeutic Alternatives

- Dosing varies by drug product. See FDA approved dosing and administration.

Appendix C: Contraindications/Boxed Warnings

- Refer to Clinical Pharmacology or other appropriate clinical resource.

IV. Dosage and Administration

A. Varies by drug product. See FDA approved dosing and administration.

V. Product Availability

A. Varies by drug product. Please refer to Clinical Pharmacology or other appropriate clinical resource for product availability.

VI. References

Refer to package inserts.

Reviews, Revisions, and Approvals	Date	Approval Date
Policy created	10/19	

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.