Topical Immunomodulators (Elidel®, Protopic®, generics)

Policy # 00524
Original Effective Date: 01/01/2017
Current Effective Date: 07/08/2024

Applies to all products administered or underwritten by Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana, Inc.(collectively referred to as the "Company"), unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

When Services May Be Eligible for Coverage

Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- *Benefits are available in the member's contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Based on review of available data, the Company may consider brand/generic Protopic®‡ (tacrolimus ointment) and brand/generic Elidel®‡ (pimecrolimus cream) for the treatment of atopic dermatitis or vitiligo to be **eligible for coverage**** when the patient selection criteria are met.

Patient Selection Criteria

Coverage eligibility for brand/generic Protopic (tacrolimus ointment) or brand/generic Elidel (pimecrolimus cream) will be considered when the following criteria are met for the requested indication and drug:

- For the treatment of atopic dermatitis:
    - Requested drug is brand/generic Protopic (tacrolimus ointment):
        - Patient has a diagnosis of moderate to severe atopic dermatitis, AND
        - Patient has tried and failed (e.g. intolerance or inadequate response) one prescription generic topical corticosteroid agent for the condition unless clinical evidence or patient history suggests the use of prescription generic topical corticosteroid agents will be ineffective or cause an adverse reaction to the patient (e.g. atopic dermatitis lesions in sensitive areas such as the face or genital areas); AND
        - If the request is for the brand Protopic, patient has tried and failed (e.g. intolerance or inadequate response) generic tacrolimus ointment unless clinical evidence or patient history suggests the use of generic tacrolimus ointment will be ineffective or cause an adverse reaction to the patient.

*(Note: This specific patient selection criterion is an additional Company requirement for coverage eligibility and will be denied as not medically necessary** if not met.)*

- Requested drug is brand/generic Elidel (pimecrolimus cream):
  - Patient has a diagnosis of mild to moderate atopic dermatitis, AND
  - Patient has tried and failed (e.g. intolerance or inadequate response) one prescription generic topical corticosteroid agent for the condition unless clinical evidence or patient history suggests the use of prescription generic topical corticosteroid agents will be ineffective or cause an adverse reaction to the patient (e.g. atopic dermatitis lesions in sensitive areas such as the face or genital areas); AND
  - If the request is for the brand Elidel, patient has tried and failed (e.g. intolerance or inadequate response) generic pimecrolimus cream unless clinical evidence or patient history suggests the use of prescription generic pimecrolimus cream will be ineffective or cause an adverse reaction to the patient.

    *(Note: This specific patient selection criterion is an additional Company requirement for coverage eligibility and will be denied as not medically necessary** if not met.)*

- For the treatment of vitiligo:
  - Requested drug is generic tacrolimus ointment; AND
  - The patient has a diagnosis of vitiligo and ONE of the following:
    - Patient has tried and failed (e.g. intolerance or inadequate response) one prescription generic topical corticosteroid agent for a clinically sufficient duration unless clinical evidence or patient history suggests the use of prescription generic topical corticosteroid agents will be/was ineffective or will/did cause an adverse reaction to the patient; OR
    - Disease is on the patient's face or other sensitive area (i.e. neck or skin folds)
- For the treatment of perioral dermatitis:
  - Requested drug is a pimecrolimus product; AND
  - Patient has tried and failed zero therapy (i.e., discontinuation of topical corticosteroids and other skin care products) for at least 4 weeks unless there is clinical evidence or patient history that suggests zero therapy will be ineffective or cause an adverse reaction to the patient; AND

- If the request is for the brand Elidel, patient has tried and failed (e.g., intolerance or inadequate response) generic pimecrolimus cream unless there is clinical evidence or patient history that suggests the use of the prescription generic product will be ineffective or cause an adverse reaction to the patient.
  *(Note: This specific patient selection criterion is an additional Company requirement for coverage eligibility and will be denied as not medically necessary** if not met.)*

When Services Are Considered Not Medically Necessary

Based on review of available data, the Company considers the use of brand Protopic or brand Elidel when the patient has not tried and failed the generic alternative of the requested brand to be **not medically necessary.****

When Services Are Considered Investigational

Coverage is not available for investigational medical treatments or procedures, drugs, devices or biological products.

Based on review of available data, the Company considers the use of brand/generic Protopic (tacrolimus ointment) or brand/generic Elidel (pimecrolimus cream) for any indication other than atopic dermatitis, perioral dermatitis, or vitiligo (generic tacrolimus ointment only) to be **investigational.***

Based on review of available data, the Company considers the use of brand/generic Protopic (tacrolimus ointment) or brand/generic Elidel (pimecrolimus cream) WITHOUT evidence that the patient has tried and failed one prescription generic topical corticosteroid agent for the condition to be **investigational.***

Background/Overview

Protopic is available as 0.03% and 0.1% strengths in ointment form. Protopic is also available as a generic under its active ingredient name, tacrolimus. Protopic and its generic are indicated for second line therapy for the short term and 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. Elidel is available in a 1% cream and also as a generic under its active ingredient name, pimecrolimus. Elidel and its generic carry a similar indication to Protopic but are for mild to moderate atopic dermatitis. First line agents for the treatment of atopic dermatitis include topical corticosteroid agents (many of which are available in generic forms). Given that various topical corticosteroids exist in generic form, these offer a more economical, yet clinically effective alternative for treatment versus the topical immunomodulator agents.

Tacrolimus ointment is commonly used for the treatment of vitiligo on the face or areas at high risk for skin atrophy. Other treatment options for vitiligo include topical corticosteroids, phototherapy, and systemic corticosteroids. Topical corticosteroids may be more effective than topical tacrolimus ointment for non-facial vitiligo but are associated with skin atrophy and other adverse events when used for a prolonged period.

Perioral dermatitis is a skin disorder that typically presents with multiple small, inflammatory papules around the mouth, nose, or eyes. Its cause is unknown but may be related to topical corticosteroid use and irritants. Initial treatment for all patients involves the discontinuation of topical corticosteroids and avoidance of topical products (such as skin care products) that may promote or exacerbate the condition. This is known as “zero therapy.” Pharmacologic therapy involves topical therapy with either topical pimecrolimus, topical erythromycin, or topical metronidazole. Because there is lack of efficacy data comparing the various topical treatment options, treatment selection is often based on factors such as availability, cost, clinician familiarity, and patient preference. Topical erythromycin and metronidazole may be more economical treatment options than pimecrolimus. In patients with moderate to severe disease, systemic therapy with oral tetracyclines or erythromycin is often used.

FDA or Other Governmental Regulatory Approval

U.S. Food and Drug Administration (FDA)

Protopic was approved in 2000, and Elidel was approved in 2001. Both carry indications for the second line treatment of atopic dermatitis.

Topical Immunomodulators (Elidel®, Protopic®, generics)

Policy # 00524
Original Effective Date: 01/01/2017
Current Effective Date: 07/08/2024

Rationale/Source

This medical policy was developed through consideration of peer-reviewed medical literature generally recognized by the relevant medical community, U.S. Food and Drug Administration approval status, nationally accepted standards of medical practice and accepted standards of medical practice in this community, technology evaluation centers, reference to federal regulations, other plan medical policies, and accredited national guidelines.

The patient selection criteria presented in this policy takes into consideration clinical evidence or patient history that suggests a prescription generic topical corticosteroid agent will be/was ineffective or will/did cause an adverse reaction to the patient. Based on a review of the data, in the absence of the above mentioned caveats, there is no advantage of using brand/generic Protopic (tacrolimus ointment) or brand/generic Elidel (pimecrolimus cream) over a prescription generic topical corticosteroid agent.

References

1. Protopic [package insert]. Astellas Pharma. Deerfield, Illinois. Updated November 2011.
2. Elidel [package insert]. Valeant Pharmaceuticals. Bridgewater, New Jersey. March 2014.
3. Vitiligo: Management and prognosis. UpToDate. November 2022.
4. Perioral (periorificial) dermatitis. UpToDate. May 2022.

Policy History

Original Effective Date: 01/01/2017
Current Effective Date: 07/08/2024

08/04/2016	Medical Policy Committee review
08/17/2016	Medical Policy Implementation Committee approval. New policy.
08/03/2017	Medical Policy Committee review
08/23/2017	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
06/07/2018	Medical Policy Committee review
06/20/2018	Medical Policy Implementation Committee approval. Added vitiligo indication for generic tacrolimus ointment.
08/01/2019	Medical Policy Committee review

Topical Immunomodulators (Elidel®, Protopic®, generics)

Policy # 00524
Original Effective Date: 01/01/2017
Current Effective Date: 07/08/2024

08/14/2019	Medical Policy Implementation Committee approval. No change to coverage.
03/05/2020	Medical Policy Committee review
03/11/2020	Medical Policy Implementation Committee approval. Requirement to try and fail generic alternatives added to criteria for atopic dermatitis indications. Background information updated to include generic pimecrolimus.
03/04/2021	Medical Policy Committee review
03/10/2021	Medical Policy Implementation Committee approval. Re-worded coverage criterion regarding trial and failure of generic products for clarity. No change to coverage.
03/03/2022	Medical Policy Committee review
03/09/2022	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
04/06/2023	Medical Policy Committee review
04/12/2023	Medical Policy Implementation Committee approval. No change to coverage.
06/01/2023	Medical Policy Committee review
06/14/2023	Medical Policy Implementation Committee approval. Updated criteria and background information to allow coverage of pimecrolimus for perioral dermatitis.
06/06/2024	Medical Policy Committee review
06/12/2024	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.

Next Scheduled Review Date: 06/2025

*Investigational – A medical treatment, procedure, drug, device, or biological product is Investigational if the effectiveness has not been clearly tested and it has not been incorporated into standard medical practice. Any determination we make that a medical treatment, procedure, drug, device, or biological product is Investigational will be based on a consideration of the following:

A. Whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and whether such approval has been granted at the time the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or

B. Whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:
    1. Consultation with technology evaluation center(s);
    2. Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
    3. Reference to federal regulations.

**Medically Necessary (or "Medical Necessity") - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

A. In accordance with nationally accepted standards of medical practice;
B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "nationally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

‡ Indicated trademarks are the registered trademarks of their respective owners.

NOTICE: If the Patient's health insurance contract contains language that differs from the BCBSLA Medical Policy definition noted above, the definition in the health insurance contract will be relied upon for specific coverage determinations.

Topical Immunomodulators (Elidel®, Protopic®, generics)

Policy # 00524
Original Effective Date: 01/01/2017
Current Effective Date: 07/08/2024

NOTICE: Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Company recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.

NOTICE: Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.