Clinical Policy: Antipsoriatics, Topical

Reference Number: PHW.PDL.147
Effective Date: 01/01/2020
Last Review Date: 11/2025

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 PA Health & Wellness® that Topical Antipsoriatics are **medically necessary** when the following criteria are met:

I. Requirements for Prior Authorization of Antipsoriatics, Topical

A. Prescriptions That Require Prior Authorization

Prescriptions for Antipsoriatics, Topical that meet the following conditions must be prior authorized:

1. A non-preferred Antipsoriatic, Topical.

2. An Antipsoriatics, Topical with a prescribed quantity that exceeds the quantity limit.

3. A topical aryl hydrocarbon receptor (AhR) agonist (e.g., tapinarof).

4. A topical phosphodiesterase type 4 (PDE4) inhibitor (e.g., roflumilast).

B. Clinical Review Guidelines and Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for an Antipsoriatic, Topical, the determination of whether the requested prescription is medically necessary will take into account whether the member:

1. Is prescribed the Antipsoriatic, Topical for the treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication; **AND**

2. Is age-appropriate according to FDA-approved package labeling, national compendia, or peer-reviewed medical literature; **AND**

3. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

4. Does not have a contraindication to the prescribed Antipsoriatic, Topical; **AND**

5. For a topical AhR agonist (e.g., tapinarof), **both** of the following:
   a. **One** of the following:
      i. For treatment of atopic dermatitis, see PHW.PDL.034 Immunomodulators, Dermatologics,
      ii. For treatment of psoriasis, has a history of therapeutic failure of or a contraindication or an intolerance to **both** of the following:
         a) A four-week trial of a topical corticosteroid approved or medically accepted for the treatment of the member's diagnosis,
         b) An eight-week trial of a non-steroidal topical pharmacologic approved or medically accepted for the treatment of the member's diagnosis (e.g., topical calcineurin inhibitor, topical retinoid, topical vitamin D analog),
      iii. For treatment of all other diagnoses, has a history of therapeutic failure of or a contraindication or an intolerance to first line therapy(ies) if applicable according to consensus treatment guidelines,
   b. For a non-preferred topical AhR agonist, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred topical AhR agonists approved or medically accepted for the member's diagnosis,

6. For a topical PDE4 inhibitor (e.g., roflumilast), **both** of the following:
   a. **One** of the following:
      i. For treatment of atopic dermatitis, see the prior authorization guideline for Immunomodulators, dermatologics,
      ii. For treatment of psoriasis, has a history of therapeutic failure of or a contraindication or an intolerance to topical calcipotriene,
      iii. For treatment of seborrheic dermatitis, has a history of therapeutic failure of or a contraindication or an intolerance to at least **one** of the following:
         a) A four-week trial of a topical antifungal approved or medically accepted for the treatment of the member's diagnosis,
         b) A four-week trial of a topical corticosteroid approved or medically accepted for the treatment of the member's diagnosis,
         c) A four-week trial of a topical calcineurin inhibitor approved or medically accepted for the treatment of the member's diagnosis,
      iv. For treatment of all other diagnoses, has a history of therapeutic failure of or a contraindication or an intolerance to first line therapy(ies) if applicale according to consensus treatment guidelines,
   b. For a non-preferred topical PDE4 inhibitor, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred topical PDE4 inhibitors approved or medically accepted for the member's diagnosis;

7. For all other non-preferred Antipsoriatics, Topical, has a history of therapeutic failure, contraindication or intolerance to the preferred Antipsoriatics, Topical approved or medically accepted for the treatment of the member's diagnosis, **AND**

8. If a prescription for an Antipsoriatics, Topical is in a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in PA.CP.PMN.59 Quantity Limit Override.

NOTE: If the member does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the member, the request for prior authorization will be approved.

FOR RENEWALS OF PRIOR AUTHORIZATION FOR ANTIPSORIATICS, TOPICAL: The determination of medical necessity of a request for renewal of a prior authorization for an Antipsoriatics, Topical that was previously approved will take into account whether the member:

1. Has documentation of a positive clinical response to the prescribed drug; **AND**

2. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

3. For a non-preferred topical AhR agonist, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred topical AhR agonists approved or medically accepted for the member's diagnosis; **AND**

4. For a non-preferred topical PDE4 inhibitor, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred topical PDE4 inhibitors approved or medically accepted for the member's diagnosis; **AND**

5. For all other non-preferred Antipsoriatics, Topical, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Antipsoriatics, Topical approved or medically accepted for the treatment of the member's diagnosis; **AND**
6. If a prescription for an Antipsoriatics, Topical is in a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in PA.CP.PMN.59 Quantity Limit Override.

NOTE: If the member does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the member, the request for prior authorization will be approved.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above, to assess the medical necessity of the request for a prescription for an Antipsoriatic, Topical. If the guidelines in Section B are met, the

reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the member.

D. **Approval Duration: duration of request or 6 months (whichever is less)**

Reviews, Revisions, and Approvals	Date
Policy created	09/01/2019
Q3 2020 annual review: no changes.	07/2020
Q1 2021 annual review: no changes.	01/2021
Q1 2023 annual review: policy revised according to DHS revisions effective 01/09/2023	10/2022
Q1 2024 annual review: no changes.	11/2023
Q1 2025 annual review: no changes.	11/2024
Q1 2026: policy revised according to DHS revisions effective 01/05/2026.	11/2025