Pharmacy Medical Necessity Guidelines: Calcipotriene 0.005%/betamethasone dipropionate 0.064% (Taclonex®)

Effective: January 13, 2026

Prior Authorization Required	√	Type of Review – Care Management	
Not Covered		Type of Review – Clinical Review	√
Pharmacy (RX) or Medical (MED) Benefit	RX	Department to Review	RXUM

These pharmacy medical necessity guidelines apply to the following:
☒ Tufts Health RITogether – A Rhode Island Medicaid Plan

Fax Numbers:
RXUM: 617.673.0939

Note: This guideline does not apply to Medicare Members (includes dual eligible Members).

OVERVIEW

FDA-APPROVED INDICATIONS

Taclonex (calcipotriene/betamethasone) ointment is a vitamin D analogue and corticosteroid combination product indicated for the treatment of plaque psoriasis in patients 12 years and older.

Taclonex (calcipotriene/betamethasone) suspension is indicated for the treatment of plaque psoriasis of the scalp and body in patients in patients 12 years and older.

COVERAGE GUIDELINES

The plan may authorize coverage of Taclonex (calcipotriene/betamethasone) ointment or suspension for Members when the following criterion is met and limitations do not apply:

1. The Member had an inadequate response or adverse reaction to or the provider indicates clinical inappropriateness of concomitant therapy with, the individual agents calcipotriene 0.005% and betamethasone 0.05%

LIMITATIONS

1. Requests for brand-name products, with AB-rated generics, will also be reviewed according to Brand Name Medications criteria.

CODES

None

REFERENCES

1. Taclonex (calcipotriene/betamethasone ointment) [prescribing information]. Madison, NJ: Leo Pharma Inc; January 2023.
2. Taclonex (calcipotriene/betamethasone suspension) [prescribing information]. Madison, NJ: Leo Pharma Inc; August 2020.

APPROVAL HISTORY

October 11, 2022: Reviewed by Pharmacy & Therapeutics Committee, approval duration is limited to one year.
Subsequent endorsement date(s) and changes made:

1. May 9, 2023: No changes.
2. January 9, 2024: Effective February 1, 2024, updated the previous trial language from "tried and failed" to "inadequate response or adverse reaction." Also, the fax number for RxUM.
3. January 14, 2025: No changes
4. January 13, 2026: No changes.

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical

Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.

Provider Services