Harvard Pilgrim Health Care | TUFTS Health Plan

Pharmacy Medical Necessity Guidelines:

Eucrisa (crisaborole) Step Therapy Program

Effective: June 9, 2026

Guideline Type	☐ Prior Authorization ☐ Non-Formulary ☒ Step-Therapy ☐ Administrative

Applies to:

Commercial Products

☒ Harvard Pilgrim Health Care Commercial products; Fax: 617-673-0988

☒ Tufts Health Plan Commercial products; Fax: 617-673-0988

Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax: 617-673-0988

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to ensure that prior authorization has been obtained.

Overview

Food and Drug Administration – Approved Indications

Eucrisa (crisaborole) is a phosphodieterase-4 (PDE-4) inhibitor indicated for topical treatment of mild to moderate atopic dermatitis (AD) in adult and pediatric patients 3 months of age and older.

Eucrisa provides an alternative to topical corticosteroids and topical calcineurin inhibitors.

Clinical Guideline Coverage Criteria

Note: Prescriptions that meet the initial step therapy requirements will adjudicate **automatically** at the point of service. If the patient does not meet the initial step therapy criteria, the prescription will deny at the point of service with a message indicating that prior authorization (PA) is required. Refer to the Coverage Criteria below and submit PA requests to the plan for patients who do not meet the step therapy criteria at the point of service.

Refer to the table below for formularies and medications subject to this policy:

Drug	Commercial and Public Plan Products
Step-1	
pimecrolimus cream	Covered as listed on formulary
tacrolimus ointment	
topical corticosteroids	
Step-2	
Eucrisa	Requires prior use of drug on Step-1

Automated Step Therapy Coverage

The following stepped approach applies to coverage of Step-2 medications by the plan:

- The patient has had a trial of a one (1) Step-1 medication as evidenced by a previous paid claim under the prescription benefit administered by the plan.

Coverage Criteria for Patients not meeting the Automated Step Therapy Coverage Criteria at the Point of Sale:

The plan may cover medications on Step-2 if the following criteria are met:

1. The patient has had a trial of a Step-1 medication as evidenced by physician's documented use

OR

2. The patient has a physician documented contraindication or intolerance to all of the Step-1 medications

Limitations

None

Codes

None

References

1. Eucrisa (crisaboole) [prescribing information]. New York, NY: Pfizer Labs; Apr 2023.
2. Ference JD, Last AR. Choosing topical corticosteroids. *Am Fam Physician*. 2009; 79(2):135-40.
3. Frankel HC, Qureshi AA. Comparative effectiveness of topical calcineurin inhibitors in adult patients with atopic dermatitis. *Am J Clin Dermatol*. 2012; 13(2):113-23
4. Garside R, Stein K, Castelnuovo E et al. The effectiveness and cost-effectiveness of pimecrolimus and tacrolimus for atopic eczema: a systematic review and economic evaluation. *Health Technol Assess*. 2005; 9(29): iii, xi-iii, 230.
5. Hanifin JM, Paller AS, Eichenfield L et al. Efficacy and safety of tacrolimus ointment treatment for up to 4 years in patients with atopic dermatitis. J Am Acad Dermatol. 2005; 53(2 Suppl 2):S186-S194.
6. Paller AS, Tom WL, Lebwohl MG et al. Efficacy and safety of crisaborole ointment, a novel, nonsteroidal phosphodiesterase 4 (PDE4) inhibitor for the topical treatment of atopic dermatitis (AD) in children and adults. J Am Acad Dermatol. 2016; 75(3):494-503.e4.
7. AAAAI/ACAA JTF Atopic Dermatitis Guideline Panel, et al. Atopic dermatitis (eczema) guidelines: 2023 American Academy of Allergy, Asthma and Immunology/American College of Allergy, Asthma and Immunology Joint Task Force on Practice Parameters GRADE- and Institute of Medicine-based recommendations. Ann Allergy Asthma Immunol. 2023 Dec; S1081-1206(23)01455-2.
8. Boguniewicz MD, et al. Atopic dermatitis yardstick update. Ann Allergy Asthma Immunol. 2023 June;130(6):811-20.
9. Eleftheriadou V, et al. British Association of Dermatologists guidelines for the management of people with vitiligo 2021. British Journal of Dermatology. 2021 Jun;186(1):18-29.
10. Sidbury R, et al. Guidelines of care for the management of atopic dermatitis in adults with topical therapies. Journal of the American Academy of Dermatology. 2023 Jul;89(1): E1-E20.
11. Taieb A, et al. Guidelines for the management of vitiligo: the European Dermatology Forum Consensus. British Journal of Dermatology. 2012 Jul;168:5-19

Approval And Revision History

September 13, 2022: Reviewed by the Pharmacy & Therapeutics Committee.

- August 8, 2023: No changes
- March 12, 2024: Updated step therapy program to include only Step 1 medications for approval of Step 2 medications. Updated lookback period for a Step 1 medication to lifetime (effective 6/1/24).
- June 10, 2025: No changes (eff 6/10/25)
- June 9, 2026: Administrative update to remove CareLink from the Medical Necessity Guideline template.

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.