Pharmacy Medical Necessity Guidelines: Immunomodulators, Topical

Effective: September 9, 2025

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

Imiquimod is indicated for:

- Actinic keratosis (all strengths): For the topical treatment of clinically typical, nonhyperkeratotic, nonhypertrophic, visible or palpable actinic keratoses on the full face or balding scalp in immunocompetent adults.
- Genital and perianal warts (3.75% and 5% cream only): For the treatment of external genital and perianal warts (condyloma acuminata) in patients 12 years and older.
- Superficial basal cell carcinoma (5% cream only): For the topical treatment of biopsy-confirmed, primary superficial basal cell carcinoma in immunocompetent adults with a maximum tumor diameter of 2 cm located on the trunk (excluding anogenital skin), neck, or extremities (excluding hands and feet), when surgical methods are medically less appropriate and patient follow-up can be reasonably ensured

For actinic keratosis, **imiquimod (Zyclara®) 2.5% and 3.75%** treatment consists of up to 2 packets or pumps per day for two 14-day cycles separated by a 14-day rest period with no treatment; dosing should not to exceed 56 packets or pumps per complete course of treatment (two 14-day cycles).

Pimecrolimus is indicated as second-line therapy for short-term and noncontinuous long-term treatment of mild to moderate atopic dermatitis in non-immunocompromised patients 2 years and older who have failed to respond adequately to other topical prescription treatments, or when those treatments are not advisable.

Tacrolimus ointment, both 0.03% and 0.1% for adults, and only 0.03% for children aged 2 to 15 years, is indicated as second-line therapy for the short-term and non-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.

Tirbanibulin 1% ointment is a microtubule inhibitor approved for the topical treatment of actinic keratosis of the face or scalp. A sufficient amount of tirbanibulin should be applied to evenly cover up to 25 cm^2 treatment field on the face or scalp once daily for five consecutive days using one single-dose packet per application.

Fluorouracil 5% cream, imiquimod 5% cream and diclofenac 3% gel (Solaraze) are preferred products and are covered without prior authorization. Diclofenac 3% gel is approved for the topical treatment of actinic keratosis. Fluorouracil 0.5% cream is approved for the topical treatment of multiple actinic or solar keratoses of the face and anterior scalp. Fluorouracil 5% cream is approved for the treatment of multiple actinic or solar keratoses as well as the treatment of superficial basal cell carcinoma when conventional methods are impractical, such as with multiple lesions or difficult treatment sites.

Medication	Preferred Drug List Status	Quantity Limit
Diclofenac 3% gel (generic Solaraze)	Covered	100gm per Rx; 90 days per year
Fluorouracil 0.5%, 5% cream (generic Carac, Efudex)	Covered	n/a
Fluorouracil 2%, 5% solution	Covered	n/a

Medication	Preferred Drug List Status	Quantity Limit
Imiquimod 5% cream (generic Aldara)	Covered	n/a
Imiquimod 2.5% and 3.75% (Zyclara)	PA	Two pumps or packets per day for up to two 14 day cycles
Pimecrolimus 1% (Elidel)	PA	100 gm per 30 days
Tacrolimus 0.03%, 0.1% (generic Protopic)	PA	One (30gm or 60gm) tube per Rx
Tirbanibulin 0.1% (Klisyri)	PA	n/a

COVERAGE GUIDELINES

The plan may authorize coverage of topical immunomodulators for Members when the following criteria for a particular regimen are met and limitations do not apply:

Imiquimod 2.5% (Zyclara)

1. The Member has a diagnosis of actinic keratosis and had an inadequate response to therapy, or the provider indicated clinical inappropriateness of therapy with the preferred products, imiquimod 5% and fluorouracil

Imiquimod 3.75%

1. The Member has a diagnosis of actinic keratosis and had an inadequate response to therapy, or the provider indicated clinical inappropriateness of therapy with the preferred products, imiquimod 5% and fluorouracil

OR

2. The Member has a diagnosis of external genital warts or perianal warts and had an inadequate response to therapy, or the provider indicated clinical inappropriateness of therapy with the preferred product, imiquimod 5%

Pimecrolimus or Tacrolimus

1. The Member is at least 2 years of age

AND

2. The Member had an inadequate response to two topical anti-inflammatory agents of medium potency or greater, OR the Member is not a candidate for medium to high potency corticosteroid therapy (e.g., eyelid dermatitis or dermatitis associated with genital area eruptions)

Tirbanibulin

1. The Member has a diagnosis of actinic keratosis

AND

2. The Member has had an inadequate response to therapy with or contraindication to imiquimod 5% and fluorouracil

AND

3. The Member had an inadequate response to therapy with or contraindication to one of the following: imiquimod 2.5%, imiquimod 3.75%

	Low Potency	Medium Potency	High Potency	Very High Potency
Preferred Products	**Alclometasone 0.05% Cream/Ointment**	**Betamethasone Valerate 0.1% Cream**	**Betamethasone Dipropionate 0.05% Cream/Ointment**	**Betamethasone Dip. Augmented 0.05% Ointment/Gel**
	Fluocinolone 0.01% Cream	**Betamethasone Dipropionate 0.05% Lotion**	**Betamethasone Dip., Augmented 0.05% Cream**	
	Hydrocortisone 0.5%, 1%, 2.5% Cream/Ointment/ Lotion/Solution	**Fluocinolone 0.025% Cream/Ointment**	**Betamethasone Valerate 0.1% Ointment**	
		Fluticasone 0.05% cream/lotion, 0.005% ointment	**Desoximetasone 0.25% Cream/Ointment**	
		Hydrocortisone Valerate 0.2% Cream	**Fluocinonide 0.05% Cream/Ointment/Gel/ Solution**	
		Mometasone 0.1% Cream/Ointment/ Solution	**Triamcinolone 0.5% Cream/Ointment**	
		Triamcinolone 0.025%, 0.1% Cream/Ointment/ Lotion		
Non-Preferred Products	Desonide 0.05% Cream/Lotion/ Ointment	Flurandrenolide 0.025%, 0.05% Cream/Ointment; 4 mcg/cm^2 tape	Amcinonide 0.01% Cream/Lotion/Ointment	Clobetasol 0.05% Cream/Ointment/ Gel/Solution
		Clocortolone 0.1% Cream	Desoximetasone 0.05% Gel	Diflorasone 0.05% Ointment
		Desoximetasone 0.05% Cream/Ointment	Diflorasone 0.05% Cream	Fluocinonide 0.1% Cream
		Hydrocortisone Butyrate Cream/Ointment/ Solution	Halcinonide 0.1% Cream/Ointment	Halobetasol 0.05% Cream/Ointment/foam
		Hydrocortisone Valerate 0.2% Ointment	Halobetasol 0.01% lotion	

LIMITATIONS

1. Requests for brand-name products, which have AB-rated generics, will be reviewed according to Brand Name criteria.
2. Approval of tacrolimus ointment for Members 2 to 15 years of age will be limited to the 0.03% strength.

CODES

None

REFERENCES

1. Aldara (imiquimod) [prescribing information]. Bridgewater, NJ: Valeant Pharmaceuticals; October 2023 .
2. Amini S, et al. Nonsurgical innovations in the treatment of nonmelanoma skin cancer. J Clin Aesthet Dermatol. 2010 Jun; 3(6):20-34.
3. Carac (fluorouracil 0.5%)_cream [prescribing information]. Bridgewater, NJ: Bausch Health US, LLC; May 2021.
4. De Berker D, McGregor JM, Hughes BR, British Association of Dermatologists Therapy Guidelines and Audit. Guidelines for the Management of Actinic Keratoses. Br J Dermatol 2007 Feb;156(2):222-30.

5. Efudex (fluorouracil 5%) cream [prescribing information]. Bridgewater, NJ: Bausch Health US, LLC; March 2024.
6. Elidel (pimecrolimus) cream [prescribing information]. Bridgewater, NJ: Valeant Pharmaceuticals North America LLC; September 2020.
7. Klisyri (tirbanibulin 1% ointment) [prescribing information]. Malvern, PA: Almirall, LLC; August 2021.
8. Picato (ingenol mebutate) [prescribing information]. Parsippany, NJ: Leo Pharma; June 2022.
9. Protopic (tacrolimus) [prescribing information]. Seven Giralda Farms, Madison, NJ:LEO Pharma Inc; March 2021.
10. Solaraze (diclofenac 3% gel) [prescribing information]. Melville, NY: PharmDerm; April 2021.
11. Stockfleth E, Terhorst D, Braathen L, Cribier B, Cerio R, Ferrandiz C et al. Guidelines For the Management of Actinic Keratoses. European Dermatology Forum. October 2010.
12. Zyclara (imiquimod) [prescribing information]. Bridgewater, NJ: Bausch Health US, LLC; January 2024.

APPROVAL HISTORY

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

Subsequent endorsement date(s) and changes made:

1. September 10, 2024: Administrative change to fax number.
2. September 9, 2025: 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.