Pharmacy Medical Necessity Guidelines: Impetigo Medications

Effective: June 1, 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

Mupirocin 2% ointment is indicated for the treatment of impetigo due to *Staphyloccoccus aureus* and *Streptococcus pyogenes* in patients 2 months of age and older.

Mupirocin 2% cream is indicated for the treatment of secondarily infected traumatic skin lesions (up to 10 cm in length or 100 cm^2 in area) caused by susceptible strains of *S. aureus* and *Streptococcus pyogenes* in patients 3 months of age and older.

Retapamulin 1% ointment (Altabax) is indicated for the topical treatment of impetigo due to *Staphylococcus aureus* (methicillin-susceptible isolates only) or *Streptococcus pyogenes* in adults and children 9 months and older.

Ozenoxacin 1% cream (Xepi) is indicated for the topical treatment of impetigo due to *S. aureus* or *S. pyogenes* in adult and pediatric patents 2 months of age and older.

Medication	Preferred Drug List Status	Quantity Limit
Mupirocin 2% ointment (generic Bactroban)	Covered	n/a
Mupirocin 2% cream (generic Bactroban)	PA	60 gram per Rx
Ozenoxacin 1% cream (Xepi)	PA	30 gram per Rx

*Step therapy requires prior use of mupirocin ointment within the last 28 days

COVERAGE GUIDELINES

The plan may authorize coverage of a non-preferred product indicated for impetigo for Members when **ONE** of the following criterions is met and limitations do not apply:

1. The Member had an insufficient response to at least a 5-day course of therapy with mupirocin ointment within the last 28 days

OR

2. The Member has a contraindication or has been intolerant to mupirocin ointment in the past, or the provider documents rationale for clinical inappropriateness of treatment with mupirocin ointment

LIMITATIONS

1. Approval will be limited to one year.
2. Requests for brand-name products, which have AB-rated generics, will be reviewed according to the Brand Name criteria.

CODES

None

REFERENCES

1. Altabax (retapamulin) ointment [prescribing information]. Malvern, PA: Almirall, SA; June 2023.
2. Bactroban (mupirocin calcium) cream [prescribing information]. Research Triangle Park, NC: GlaxoSmithKline; February 2020.
3. Centany (mupirocin) ointment [prescribing information]. Fairfield, NJ: Medimetriks, Pharmaceuticals, Inc; May 2017.
4. Mupirocin 2% cream [prescribing information]. Bedminster, NJ: Alembic Pharmaceuticals, Inc.; December 2023.
5. Mupirocin 2% ointment [prescribing information]. Allegan, MI: Padagis; January 2022.

6. Xepi (ozenoxacin) cream [prescribing information]. Woburn, MA: Biofrontera Inc; January 2020.

APPROVAL HISTORY

October 11, 2022: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:

1. August 8, 2023: No changes.
2. May 14, 2024: Effective June 1, 2024, updated RxUM fax number.
3. May 13, 2025: No changes
4. May 12, 2026: Effective June 1, 2026, removed Cetany and Altabax from the MNG due to product discontinuation.

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