PRIOR AUTHORIZATION CRITERIA

<table>
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<tr>
<th>BRAND NAME</th>
<th>ELIDEL (generic) (pimecrolimus)</th>
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**Status:** CVS Caremark Criteria  
**Type:** Initial Prior Authorization

**POLICY**

**FDA-APPROVED INDICATIONS**

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

Elidel is not indicated for use in children less than 2 years of age.

**Compendial Use:**

Psoriasis on the face, genitals, or skin folds. 3,5,6  
Vitiligo on the head or neck.2,3,8,9

**COVERAGE CRITERIA**

- Elidel (pimecrolimus) will be covered with prior authorization when the following criteria are met:
  - The patient is 2 years of age or older
  - Elidel is being prescribed for short-term or noncontinuous chronic use for one of the following: psoriasis on the face, genitals, or skin folds, or vitiligo on the head or neck  
  - Elidel is being prescribed for short-term or noncontinuous chronic use for mild to moderate atopic dermatitis (eczema)  
    - Elidel will be used on the face, body skin folds, genital area, armpit, or around the eyes  
    - The patient has experienced an inadequate treatment response, intolerance, or contraindication to at least one first line therapy agent (e.g., medium or higher potency topical steroid)
  - OR
  - The patient is less than 2 years of age
    - Elidel is being prescribed for short-term or noncontinuous chronic use for one of the following: psoriasis on the face, genitals, or skin folds, vitiligo on the head or neck
    - Elidel is being prescribed for short-term or noncontinuous chronic use for mild to moderate atopic dermatitis (eczema)

**REFERENCES**

