PRIOR AUTHORIZATION CRITERIA

BRAND NAME	**PROTOPIC**
(generic)	**(tacrolimus)**

Status: CVS Caremark Criteria
Type: Initial Prior Authorization

POLICY

COVERAGE CRITERIA

- Protopic (tacrolimus) will be covered with prior authorization when the following criteria are met:
  - For Protopic (tacrolimus) 0.1% ointment, the patient is 16 years of age or older

    AND
  - Protopic (tacrolimus) 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

    OR
  - Protopic (tacrolimus) is being prescribed for short-term or noncontinuous chronic use for moderate to severe atopic dermatitis (eczema)

    AND
    - Protopic (tacrolimus) will be used on the face, body skin folds, genital area, armpit, or around the eyes

      OR
    - 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
  - For Protopic (tacrolimus) 0.03% ointment, the patient is 2 years of age or older

    AND
  - Protopic (tacrolimus) 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

    OR
  - Protopic (tacrolimus) is being prescribed for short-term or noncontinuous chronic use for moderate to severe atopic dermatitis (eczema)

    AND
    - Protopic (tacrolimus) will be used on the face, body skin folds, genital area, armpit, or around the eyes

      OR
    - 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)

REFERENCES

1. Assurant Health Prior Authorization Approval Policy.

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