Missouri Pharmacy Program – Preferred Drug List

Actinic Keratosis Agents – Topical

Effective 07/13/2017
Revised 07/11/2019

Preferred Agents

• Fluorouracil 5% Crm (gen Efudex®)
• Fluorouracil Soln
• Imiquimod (gen Aldara®)

Non-Preferred Agents

• Aldara®
• Carac®
• Diclofenac 3% Gel
• Efudex® Crm
• Fluorouracil 0.5% Crm (gen Carac®)
• Imiquimod 3.75% (gen Zyclara® Pump)
• Picato®
• Solaraze® 3%
• Tolak™
• Zyclara®

Approval Criteria

• Failure to achieve desired therapeutic outcomes with trial on 1 or more preferred agents
  o Documented trial period for preferred agents
  o Documented ADE/ADR to preferred agents

Denial Criteria

• Lack of adequate trial on required preferred agents
• Therapy will be denied if no approval criteria are met
• Drug Prior Authorization Hotline: (800) 392-8030