# Missouri Pharmacy Program – Preferred Drug List

## Atopic Dermatitis (Immunomodulators)

**Effective 03/20/2008**  
**Revised 08/08/2019**

<table>
<thead>
<tr>
<th>Preferred Agents</th>
<th>Non-Preferred Agents</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Elidel®</td>
<td>• Eucrisa™</td>
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<td></td>
<td>• Pimecrolimus</td>
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<td></td>
<td>• Protopic®</td>
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<tr>
<td></td>
<td>• Tacrolimus</td>
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</tbody>
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### Approval Criteria

**Preferred Products:** Elidel®  
- Age 2 years and older  
- Diagnosis of Atopic Dermatitis

**Non-Preferred Products:**  
- Protopic®, Tacrolimus 0.03%  
  - Age 2 years and older  
  - Failure to achieve desired therapeutic outcomes with trial on 1 or more preferred agents  
    - Documented trial period of preferred agents  
    - Documented ADE/ADR to preferred agents

- Eucrisa®  
  - Age 2 years and older  
  - Diagnosis of Atopic Dermatitis  
  - Available after adequate trial of a medium or high potency topical corticosteroid and/or Elidel® defined as 90 days of total therapy out of 120 days  
  - Limit of 240gms in 365 days

### 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