Missouri Pharmacy Program – Preferred Drug List

Atopic Dermatitis (Immunomodulators)

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

Preferred Agents

- Elidel®

Non-Preferred Agents

- Eucrisa™
- Pimecrolimus
- Protopic®
- Tacrolimus

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