PRIOR AUTHORIZATION CRITERIA

BRAND NAME (generic)

PROTOPIC (tacrolimus)

Status: CVS Caremark Criteria
Type: Initial Prior Authorization

POLICY

FDA-APPROVED INDICATIONS
Protopic Ointment, both 0.03% and 0.1% for adults, and only 0.03% for children aged 2 to 15 years, is indicated as second-line therapy for the short-term and non-continuous chronic treatment of moderate to severe atopic dermatitis in non-immunocompromised adults and children who have failed to respond adequately to other topical prescription treatments for atopic dermatitis, or when those treatments are not advisable.

Protopic ointment is not indicated for children younger than 2 years of age.

Compendial Uses:
Psoriasis on the face, genitals, or skin folds.3,8,9
Vitiligo on the head or neck.2,3,10,11

COVERAGE CRITERIA
The requested drug will be covered with prior authorization when the following criteria are met:

- If the request is for Protopic (tacrolimus) 0.1% ointment, the patient is 16 years of age or older
  AND
  - The requested drug is being prescribed for psoriasis on the face, genitals, or skin folds OR vitiligo on the head or neck
  OR
  - The requested drug is being prescribed for moderate to severe atopic dermatitis (eczema)
    AND
    - The requested drug will be used around the eyes, on the face, genitals, or skin folds
    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 corticosteroid)
    OR
    - The patient is less than 2 years of age AND unable to use a first line therapy agent (e.g., medium or higher potency topical corticosteroid)

REFERENCES