PRIOR AUTHORIZATION CRITERIA

<table>
<thead>
<tr>
<th>BRAND NAME</th>
<th>ELIDEL</th>
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<td>(generic)</td>
<td>(pimecrolimus)</td>
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Status: CVS Caremark Criteria  
Type: Initial Prior Authorization

POLICY

FDA-APPROVED INDICATIONS
Elidel is indicated as second-line therapy for the short-term and noncontinuous chronic treatment of mild to moderate atopic dermatitis in non-immunocompromised adults and children 2 years of age and older, who have failed to respond adequately to other topical prescription treatments, or when those treatments are not advisable.

Elidel is not indicated for use in children less than 2 years of age.

Compendial Uses:  
Psoriasis on the face, genitals, or skin folds.  
Vitiligo on the head or neck.

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

- 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 mild to moderate atopic dermatitis (eczema)
  AND
  - The requested drug 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  
  - The patient is less than 2 years of age

REFERENCES