

MEDICATION COVERAGE POLICY

PHARMACY AND THERAPEUTICS ADVISORY COMMITTEE

POLICY	Other Skin Disorders	P&T DATE:	12/22/2021
THERAPEUTIC CLASS	Dermatology	REVIEW HISTORY	12/20, 12/19, 12/18, 5/17,
LOB AFFECTED	Medi-Cal	(MONTH/YEAR)	9/15, 5/15, 11/14, 9/11, 5/09

This policy has been developed through review of medical literature, consideration of medical necessity, generally accepted medical practice standards, and approved by the HPSJ Pharmacy and Therapeutic Advisory Committee.

OVERVIEW

WOUND CARE

Wound care can be difficult to manage since wound type, size, location, ease of application, and other factors are all considerations that affect the wound care agent selected. Depending on the type of wounds, it may take anywhere from days to months for wounds to heal so the therapeutic benefits of some of these agents is not always immediately apparent. This review will examine the standards of practice for wound care management and the available formulary wound care products and their coverage criteria.

ACNE VULGARIS

Acne vulgaris is a common disease in adolescents with a reported prevalence of 70-87%. This disease state is a cause for concern due to the psychosocial impact among patients. There are multiple drug combinations with different mechanisms to treat acne vulgaris, but this depends on the severity of acne: mild, moderate, or severe. This review will examine the treatment guidelines of acne vulgaris and the currently available acne drug products and their coverage criteria.

ATOPIC DERMATITIS

Atopic dermatitis (AD) is a chronic inflammatory skin disease associated with skin barrier dysfunction, immune dysregulation, and itchiness. AD affects approximately 3% of adults in the United States.¹ It is hypothesized that an abnormality in the filaggrin gene causes dysfunctional skin proteins to be synthesized, resulting in poorly hydrated skin and altered barrier function. The abnormal immune response occurs due to abnormal Th2 immune cells that release cytokines (including IL-4 and IL-13) which propagate inflammation. Patients can experience dry, scaly, itchy skin. Other symptoms include pain, sweating, bleeding, oozing, cracking, flaking and a heat sensation. Complications of AD include skin thickening and skin fissures due to chronic scratching. Patients with AD are also predisposed to infectious disease of the skin by bacteria and viruses. They also experience a reduced quality of life due to disrupted sleep, and reduced social and mental health.² This review will examine the treatment guidelines of atopic dermatitis and the currently available products and their coverage criteria.

Table 1: Available Wound Care Agents (Current as of 9/2021)

Topical Agents					
Therapeutic Class	Generic Name (Brand Name)	Available Strengths	Formulary Limits	Average Cost per 30 days	Notes
Topical Anti-bacterials	Gentamicin <i>Cream, Ointment</i>	0.1%	-	\$28.12	
	Bacitracin Zinc <i>Ointment, Packet</i>	500 Unit/Gm	-	\$2.29	
	Mupirocin (Bactroban) <i>Cream, Ointment</i>	2%	-	\$5.19	
	Neomycin/Bacitra/Polymyx (Triple Antibiotic) <i>Ointment</i>	3.5mg-400 U-5,000 U/Gm	-	\$6.74	
	Neomycin/Bacitracin/Pmyx/Pramox (Neosporin Plus) <i>Ointment, Cream</i>	3.5mg-500 U-10,000 U/Gm	-	\$5.55	

	Bacitracin/Polymyxin/Pramx (Neosporin Plus) <i>Cream</i>	3.5mg-10,000 U/Gm-0.5%	-	\$5.44	
	Ozenoxacin (Xepi) <i>Cream</i>	1%	NF	-	
Topical Astringents	Calamine <i>Lotion</i>	-	-	\$0.89	
	Calamine/Zinc Oxide <i>Lotion</i>	-	-	\$1.07	
Topical Burn Product	Silver Sulfadiazine (SSD) <i>Cream</i>	1%	-	\$8.07	
Topical Anesthetic	Lidocaine-Prilocaine <i>Cream</i>	2.5%-2.5%	QL	\$9.96	Limit 30gm per month.
Wound Healing Agents	Medihoney <i>Paste</i>	-	PA	-	Requires documentation of wound description.
	Collagenase (Santyl) <i>Ointment</i>	250 U/Gm	QL	\$805.24	90gm per 30 days.
	Cadexomer Iodine (Iodosorb) <i>Gel</i>	-	PA; QL	\$125.72	Requires documentation of wound description. Max of 90 day supply.
	Becaplermin (Regranex) <i>Gel</i>	0.01%	NF	\$954.61	

NF = Non-Formulary; PA = Prior Authorization Required; QL = Quantity Limit

Table 2: Available Acne Agents (Current as of 9/2021)

Topical Agents					
Therapeutic Class	Generic Name (Brand Name)	Available Strengths	Formulary Limits	Average Cost per 30 days	Notes
Single Agents	Benzoyl Peroxide <i>Bar, Cleanser, Cream, Gel, Lotion, Wash</i>	5%, 10%	--	\$7.26	
		4%, 6%	NF	--	
	Sulfacetamide/Sulfur <i>Cleanser</i>	-	FL	\$211.97	Limit 1 fill per month.
	Clindamycin Phosphate <i>Gel, Lotion, Solution</i>	1%	--	\$393.71	
	Erythromycin Base/Ethanol <i>Gel, Solution, Swab</i>	2%	--	\$30.91	
	Tretinoin <i>Cream, Gel</i>	0.01%, 0.025%, 0.05%, 0.1%	AL	\$112.51	Restricted to use by patients <35yo. Tretinoin 0.05% Gel is non-formulary.
	Adapalene <i>Cream, Gel, Lotion</i>	0.1%, 0.3%	AL	\$120.01	Restricted to use by patients <35yo. Differin 0.1% Gel (OTC) is formulary.
	Tazarotene (Tazorac) <i>Cream, Gel</i>	0.05%, 0.1%	PA; QL	\$382.29	Reserved for treatment failure to Tretinoin + BPO AND Adapalene + BPO. Limit 30gm per month.
	Dapsone (Aczone) <i>Gel</i>	5%	PA; QL	\$156.31	Reserved for treatment failure to Tretinoin/Adapalene + Clindamycin/Erythromycin + BPO. Limit 60gm per month.
Combination Agents	All combination acne products <i>(BenzaClin, Benzamycin, Epiduo, etc)</i>		NF	-	Use agents separately.
Systemic Agents					
Therapeutic Class	Generic Name (Brand Name)	Available Strengths	Formulary Limits	Average Cost per 30 days	Notes
Oral Tetracyclines	Doxycycline Monohydrate <i>Capsule, Tablet</i>	50mg, 100mg	-	\$42.79	Doxycycline Hyclate is non-formulary.

	Minocycline Capsule	50mg, 75mg, 100mg	-	\$120.45	
	Tetracycline Capsule	20mg, 500mg	NF	-	
Oral Retinoids	Isotretinoin (Claravis, Amnesteem, Myorisan, Zenatane)	10mg, 20mg, 40mg,	QL; FL	\$297.19	Limited to 60 capsules per 30 days and a fill limit of 6 per 240 days.
	Isotretinoin (Absorica)	10mg, 20mg, 40mg	NF	-	
AL = Age Limit; NF = Non-Formulary; PA = Prior Authorization Required; QL = Quantity Limit; ST = Step Therapy; FL = Fill Limit					

Table 3: Available Atopic Dermatitis Agents (Current as of 9/2021)

Topical Agents					
Therapeutic Class	Generic Name (Brand Name)	Available Strengths	Formulary Limits	Average Cost per 30 days	Notes
Phosphodiesterase-4 Enzyme Inhibitor	Crisaborole (Eucrisa) Ointment	2%	ST, QL	\$688.37	Step Therapy for patients with atopic dermatitis who have failed treatment, shown intolerance, or has contraindication to a medium to super-high potency topical corticosteroid AND either Pimecrolimus (Elidel) or Tacrolimus (Protopic) within the past 30 days. Limited to 60 grams per 30 days.
Systemic Agents					
Therapeutic Class	Generic Name (Brand Name)	Available Strengths	Formulary Limits	Average Cost per 30 days	Notes
Interleukin-4 Receptor Antagonist	Dupilumab (Dupixent) Solution Prefilled Syringe	300 mg/2 mL (2 mL)	PA, AL	\$3,225.03	Reserved for patients 6 years of age or older with confirmed diagnosis by a dermatologist, allergist, or immunologist of chronic moderate to severe atopic dermatitis that has failed treatment, shown intolerance, or has contraindication to one or more medium to super-high potency topical corticosteroid AND Tacrolimus (Protopic) AND an adequate trial of one of the following [1] phototherapy/photochemotherapy OR [2] oral systemic therapy (e.g. azathioprine, methotrexate, mycophenolate) within the past 365 days. Documentation of allergy testing (e.g. skin, in vitro) is also required. See Respiratory -Asthma/COPD medication coverage policy for Dupixent in eosinophilic asthma and oral steroid dependent asthma.
AL = Age Limit; NF = Non-Formulary; PA = Prior Authorization Required; QL = Quantity Limit; ST = Step Therapy					
*Utilization management criteria for topical corticosteroids and topical calcineurin inhibitors are shown in the Dermatology – Psoriasis Medication Coverage Policy.					
**Utilization management criteria for mycophenolate are shown in the Immunology – Transplant Medication Coverage Policy.					

Table 4: Available Chronic Idiopathic Urticaria Agents (Current as of 9/2021)

Systemic Agents					
Therapeutic Class	Generic Name (Brand Name)	Available Strengths	Formulary Limits	Average Cost per 30 days	Notes
Anti-IgE Antibody	Omalizumab (Xolair) <i>Solution Prefilled Syringe</i>	150 mg/mL (1 mL)	PA	\$2,190.91	Reserved for patients who must have urticaria for most days of the week for longer than a duration of six weeks. Must have tried and failed monotherapy with a second generation non-sedating antihistamine up to four-fold the standard daily dose for at least 1 to 4 weeks. See Respiratory -Asthma/COPD medication coverage policy for Xolair in asthma.

AL = Age Limit; NF = Non-Formulary; PA = Prior Authorization Required; QL = Quantity Limit; ST = Step Therapy

Table 5: Available Hidradenitis Suppurativa Agents (Current as of 9/2021)

Systemic Agents					
Therapeutic Class	Generic Name (Brand Name)	Available Strengths	Formulary Limits	Average Cost per 30 days	Notes
Tumor Necrosis Factor Inhibitor	Adalimumab (Humira) <i>Prefilled Syringe and Pen-injector Kit</i>	40mg/0.8ml	PA	\$13,336.72	Reserved for patients at least 12 years of age with documented diagnosis of moderate to severe hidradenitis suppurativa for at least one year.

AL = Age Limit; NF = Non-Formulary; PA = Prior Authorization Required; QL = Quantity Limit; ST = Step Therapy

EVALUATION CRITERIA FOR APPROVAL/EXCEPTION CONSIDERATION

Below are the coverage criteria and required information for each agent. These coverage criteria have been reviewed approved by the HPSJ Pharmacy & Therapeutics (P&T) Advisory Committee. For conditions not covered under this Coverage Policy, HPSJ will make the determination based on Medical Necessity as described in HPSJ Medical Review Guidelines (UM06).

WOUND CARE

Topical Anti-bacterials (Gentamicin, Bacitracin, Mupirocin, Triple Antibiotic, Neosporin, etc)

- Coverage Criteria: None
- Limits: None
- Required Information for Approval: None
- Other Notes: None

Topical Astringents (Calamine, Calamine/Zinc Oxide)

- Coverage Criteria: None
- Limits: None
- Required Information for Approval: None
- Other Notes: None

Topical Burns (Silver Sulfadiazine, SSD)

- Coverage Criteria: None

- Limits:** None
- Required Information for Approval:** None
- Other Notes:** None

Local Anesthetic (Lidocaine/Prilocaine)

- Coverage Criteria:** None
- Limits:** Limit 30gm per month.
- Required Information for Approval:** None
- Other Notes:** None

Wound Healing Agents

Medihoney Paste

- Coverage Criteria:** For treatment of chronic ulcers/burns.
- Limits:** None
- Required Information for Approval:** Documentation of wound description.
- Other Notes:** Approved up to 3 months at a time.

Santyl Ointment

- Coverage Criteria:** None.
- Limits:** 90gm per 30 days.
- Required Information for Approval:** None.
- Other Notes:** None.

Cadexomer Gel (Iodosorb)

- Coverage Criteria:** For treatment of highly exudative or infected wounds.
- Limits:** Max duration of up to 90 days.
- Required Information for Approval:** Documentation of wound description.
- Other Notes:** Approved up to 3 months at a time.
- Non-Formulary:** Becaplermin (Regranex Gel)

ACNE

Topical Retinoids

Tretinoin (Retin-A); Adapalene (Differin)

- Coverage Criteria:** Tretinoin and Adapalene are restricted to patients under the age of 35 OR for patients 35 and older who have a diagnosis of moderate acne as evidenced by documentation of clinical evaluation by provider with treatment failure to topical Clindamycin/Erythromycin with Benzoyl Peroxide OR prescribed by a dermatologist.
- Limits:** None
- Required Information for Approval:** (Non-dermatologist prescribers) Clinic notes documenting diagnosis of moderate-severe acne with treatment failure to topical antibiotics and benzoyl peroxide; prescription history of topical/systemic antibiotics and benzoyl peroxide.
- Other Notes:** Adapalene 0.1% Gel (OTC) is formulary preferred.
- Non-Formulary:**
 - o Retin-A Micro (tretinoin microspheres)
 - o Renova (tretinoin - wrinkles)
 - o Adapalene 0.1% Gel (Rx version)
 - o Tretinoin 0.05% Gel

Tazarotene

Tazarotene (Tazorac)

- Coverage Criteria:** Tazarotene is reserved for use by Dermatologists or for patients with documented treatment failure/intolerance to Tretinoin AND Adapalene in combination with Benzoyl Peroxide.
- Limits:** 30gm per month.
- Required Information for Approval:** Prescription history of Tretinoin, Adapalene, and Benzoyl Peroxide.
- Other Notes:** None

Oral Retinoids

Isotretinoin (Amnesteem, Claravis, Myorisan, Zenatane)

- Coverage Criteria:** None
- Limits:** Limited to 60 capsules per 30 days with a fill limit of 6 per 240 days.
- Required Information for Approval:** N/A
- Non-Formulary:** *Absorica*

Oral Antibiotics

Doxycycline Monohydrate, Minocycline, Tetracycline, Erythromycin, Azithromycin, Clindamycin, Trimethoprim, Amoxicillin*

- Coverage Criteria:** None
- Limits:** None
- Required Information for Approval:** N/A
- Non-Formulary:**
 - *Tetracycline is non-formulary.*
 - *Doxycycline Hyclate is non-formulary.*

Topical Antibiotics

Clindamycin, Erythromycin

- Coverage Criteria:** None
- Limits:** None
- Required Information for Approval:** N/A

Dapsone (Aczone)

- Coverage Criteria:** Dapsone is reserved for patients with documented treatment failure/intolerance to Tretinoin/Adapalene AND topical Clindamycin/Erythromycin AND Benzoyl Peroxide.
- Limits:** 60gm per month.
- Required Information for Approval:** Prescription history of [1] Tretinoin or Adapalene [2] topical Clindamycin or Erythromycin AND [3] Benzoyl Peroxide.

OTC & Other Products

*Benzoyl Peroxide 5%, 10%; Salicylic Acid, Sulfacetamide-Sulfur**

- Coverage Criteria:** None
- Limits:** Sulfacetamide-Sulfur products are limited to 1 fill per month.
- Required Information for Approval:** N/A
- Non-Formulary:**
 - Benzoyl Peroxide 4%, 6% formulations are non-formulary.

ATOPIC DERMATITIS

Phosphodiesterase-4 Enzyme Inhibitors

Crisaborole (Eucrisa)

- Coverage Criteria:** Step Therapy for patients with atopic dermatitis who have failed treatment, shown intolerance, or has contraindication to a medium to super-high potency topical corticosteroid AND either Pimecrolimus (Elidel) or Tacrolimus (Protopic) within the past 30 days. Limited to 60 grams per 30 days.
- Limits:** 60 grams per 30 days
- Required Information for Approval:** Clinic notes documenting diagnosis of atopic dermatitis and prescription history of a medium to super-high potency topical corticosteroid AND either Pimecrolimus (Elidel) or Tacrolimus (Protopic).

Interleukin-4 Receptor Antagonists

Dupilumab (Dupixent)

- Coverage Criteria:** Prior authorization required. Reserved for patients 6 years of age or older with confirmed diagnosis by a dermatologist, allergist, or immunologist of chronic moderate to severe atopic dermatitis that has failed treatment, shown intolerance, or has contraindication to one or more medium to super-high potency topical corticosteroid AND Tacrolimus (Protopic) AND an adequate trial of one of the following [1] phototherapy/photo-chemotherapy OR [2] oral systemic therapy (e.g. azathioprine, methotrexate, mycophenolate) within the past 365 days. Documentation of allergy testing (e.g. skin, in vitro) is also required.
- Limits:** Restricted to specialty pharmacy. Must be prescribed by dermatologist, allergist, or immunologist.
- Required Information for Approval:** Clinic notes documenting diagnosis of chronic moderate to severe atopic dermatitis by a dermatologist, allergist, or immunologist. Documentation of allergy testing. Prescription history of [1] one or more medium to super-high potency topical corticosteroids, [2] tacrolimus (Protopic), and [3] an adequate trial of one of the following: phototherapy/photo-chemotherapy OR oral systemic therapy (e.g. azathioprine, methotrexate, mycophenolate).
- Other Notes:** For sensitive areas of the skin (e.g., face, neck, and other skin folds) lowest to lower-medium potency topical corticosteroids may be used.

CHRONIC IDIOPATHIC DERMATITIS

Anti-IgE Antibody

Omalizumab (Xolair)

- Coverage Criteria:** Reserved for patients who must have urticaria for most days of the week for longer than a duration of six weeks. Must have tried and failed monotherapy with a second generation non-sedating antihistamine up to four-fold the standard daily dose for at least 1 to 4 weeks.
- Limits:** None
- Required Information for Approval:** Clinic notes documenting diagnosis of chronic idiopathic urticaria. Prescription history of second generation non-sedating antihistamine.
- Other Notes:** Initial approval is for 6 months. Based on clinic notes, patient must have documented therapeutic response in the form of improved symptomology for continuing approval. If symptoms are not improved, recommend discontinuation.

HIDRADENITIS SUPPURATIVA

Tumor Necrosis Factor-Inhibitor

Adalimumab (Humira)

- Coverage Criteria:** Reserved for patients at least 12 years of age with documented diagnosis of moderate to severe hidradenitis suppurativa for at least one year.
- Limits:** Restricted to specialty pharmacy. Must be prescribed by dermatologist.
- Required Information for Approval:** Documented diagnosis of moderate to severe hidradenitis suppurativa for at least one year.
- Other Notes:** None

CLINICAL JUSTIFICATION

WOUND CARE

Hydrocolloids are a popular class among wound care agents because they can both maintain moisture as well as absorb excess fluids. However, hydrocolloids are associated with higher costs compared to other wound care agents, and due to their occlusive nature, there is higher risk of wound infections and hypergranulation.

Medihoney® Paste is used for mild-moderate exudative wounds; it has advantages over traditional hydrocolloids in that it is less costly and approved for chronic use. In addition, its formulation is less viscous, allowing the paste to reach tunneled or irregular wounds. Likewise, cadexomer iodine is another alternative to traditional hydrocolloids. Its gel-like medium and co-formulation with iodine makes it useful for highly exudative or infected wounds. The iodine component is a potential safety concern and warrants a limitation on the duration of use to 90 days as recommended by the manufacturer.

Collagenase ointment is an alternative to surgical/mechanical debridement for the management of chronic dermal ulcers (pressure, diabetic, and venous leg ulcers) and severe burns. Through various, small studies, collagenase was shown to improve wound healing as compared to standard wound dressings, and when used in addition to surgical debridement, collagenase ointment showed a reduction ulcer size. Topical debridement provides minimal pain and can be used at home by the patient or caregiver. Also, collagenase ointment does not have a maximum duration of use because of its mild debriding properties. Collagenase ointment is slow-acting and may take weeks to achieve complete debridement.

ACNE

The effectiveness of topical antibiotics, retinoids, and benzoyl peroxide for acne treatment has been well established. For mild acne, the 2016 Journal of American Academy of Dermatology and 2013 Pediatrics Journal recommend over-the-counter products (benzoyl peroxide, salicylic acid, sulfur agents) as first-line agents with or without topical antibiotics or retinoids. Moderate acne usually requires a combination of topical therapies (topical antibiotics, topical retinoids, and over-the-counter agents). Tazarotene is clinically comparable to topical tretinoin and adapalene with adapalene being more tolerable than tretinoin.³ Long-term use of oral tetracyclines antibiotics (minocycline and doxycycline) may be useful for prevention of acne flares.

Monotherapy with oral antibiotics has a similar efficacy to benzoyl peroxide in combination with topical antibiotics.⁴ Severe acne or cystic acne requires 5 to 6 months of systemic treatment with oral retinoids, often used in combination with topical therapies. For patients with hormonal-induced acne, oral contraceptives may be used as adjunctive/monotherapies therapies. While only 3 contraceptives have a labeled indication for acne management, all oral contraceptives may be used for acne treatment.⁵ Topical combination products, while formulated for convenience, are significantly less cost-effective. Consequently, combination products are non-formulary.

ATOPIC DERMATITIS

Topical agents are the mainstay of treatment in mild, moderate, and severe cases of AD. In more severe, topical agents are used in conjunction with phototherapy or systemic therapy. Topical agents used in AD treatment include moisturizers, topical corticosteroids, and topical calcineurin inhibitors.⁶ Topical corticosteroids are the mainstay of topical anti-inflammatory treatment, and are initiated after failure of good skin care and regular use of moisturizers. Topical corticosteroids should be applied twice daily for 2-4 weeks for acute flares of AD. Topical corticosteroids may be used as maintenance therapy in patients who experience frequent, repeat outbreaks. Topical corticosteroids are applied once or twice weekly in maintenance therapy. Topical calcineurin inhibitors are used second line and may be combined with topical corticosteroids. Studies show mixed results on the efficacy of topical calcineurin inhibitors with topical corticosteroids. Tacrolimus is indicated for moderate-to-severe AD and pimecrolimus is indicated for mild-to-moderate AD.

In patients with more severe disease that is not controlled with optimal topical therapy, phototherapy is recommended. Phototherapy with UVB, BB-UVB, UVA, and PUVA has been shown to be beneficial for both acute and chronic disease.⁷ Results from phototherapy are typically seen anywhere from 15-25 treatments over 2-4 weeks.⁸

Systemic therapy is recommended when optimized topical regimens and/or phototherapy do not adequately control the disease. Options for systemic therapy include calcineurin inhibitors, methotrexate, mycophenolate, and azathioprine. Among systemic agents for AD, these drugs have been widely used and have shown the most efficacy. Interferon gamma is moderately and variably effective, but may also be considered in patients where other oral therapies are not an option.⁹ Systemic steroids should be avoided unless used for an acute exacerbation because prolonged use can lead to many side effects. Leukotriene inhibitors have limited data supporting use. Insufficient data exists to recommend optimal dosing, duration of therapy and precise monitoring protocols for any systemic agent. Currently, there are no recommendations for the use of biologics in AD. The comparative efficacy of phototherapy and systemic therapy is unknown due to inconsistency between studies regarding methods.⁷

☒ REFERENCES

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REVIEW & EDIT HISTORY

Document Changes	Reference	Date	P&T Chairman
Creation of Policy	Contraceptives May09_JHP01 5-11-09.doc	5/2009	Allen Shek, PharmD
Updated Policy	OC Class Review 9-20-11.docx	9/2011	Allen Shek, PharmD
Updated Policy	Formulary Realignment PT 9-18-12.xls	9/2012	Allen Shek, PharmD
Creation of Policy	Wound Care Agents 2014-11-18.docx	11/2014	Jonathan Szkotak, PharmD
Updated Policy	Wound Care Coverage Policy.docx	05/2015	Jonathan Szkotak, PharmD, BCACP
Updated Policy	Acne Class Review.docx	5/2015	Jonathan Szkotak, PharmD
Updated Policy	HPSJ Coverage Policy – Dermatology – Acne 2015-5.docx	5/2015	Johnathan Yeh, PharmD
Updated Policy	HPSJ Coverage Policy – Dermatology – Wound Care 2015-05.docx	09/2015	Jonathan Szkotak, PharmD, BCACP
Updated Policy	HPSJ Coverage Policy – Dermatology – Wound Care 2017-05.docx	5/2017	Johnathan Yeh, PharmD
Updated Policy	HPSJ Coverage Policy – Dermatology – Acne 2017-5.docx	5/2017	Johnathan Yeh, PharmD
Updated Policy	HPSJ Coverage Policy – Dermatology – Wound Care 2018-12.docx	12/2018	Matthew Garrett, PharmD
Updated Policy	HPSJ Coverage Policy – Dermatology – Acne 2018-12.docx	12/2018	Matthew Garrett, PharmD
Updated Policy	HPSJ Coverage Policy – Dermatology – Other Skin Disorders 2019-12.docx	12/2019	Matthew Garrett, PharmD
Updated Policy	HPSJ Coverage Policy – Dermatology – Other Skin Disorders 2020-12.docx	12/2020	Matthew Garrett, PharmD
Review of Policy	Other Skin Disorders	12/2021	Matthew Garrett, PharmD

Note: All changes are approved by the HPSJ P&T Committee before incorporation into the utilization policy.