New Hampshire Medicaid Fee-for-Service Program
Skin Disorders Criteria

Approval Date: June 5, 2025

Indications

Drug	Indication(s)
Cibinqo (abrocitinib)	• Treatment of adults and pediatric patients 12 years of age or older with refractory, moderate-to-severe atopic dermatitis whose disease is not adequately controlled with other systemic drug products, including biologics, or when use of those therapies is inadvisable
Eucrisa (crisaborole)	• Topical treatment of mild to moderate atopic dermatitis in patients ≥ 3 months of age
Ebglyss (lebrikizumab-lbkz)	• Treatment of moderate-to-severe atopic dermatitis in adult and pediatric patients 12 years of age and older who weigh at least 40 kg whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable
Nemluvio (nemolizumab-ilto)	• Treatment of moderate-to-severe atopic dermatitis in adult and pediatric patients 12 years of age and older in combination with topical corticosteroids and/or calcineurin inhibitors whose disease is not adequately controlled with topical prescription therapies • Treatment of adults with prurigo nodularis
Elidel (pimecrolimus)	• Second-line therapy for the short-term and non-continuous chronic treatment of mild to moderate atopic dermatitis in non-immunocompromised adults and children 2 years of age or older who have failed to respond adequately to other topical prescription treatments or when those treatments are not advisable
Zoryve (roflumilast)	• Topical treatment of mild to moderate atopic dermatitis in patients ≥ 6 years of age
Opzelura (ruxolitinib)	• Second-line therapy for the short-term and non-continuous chronic treatment of mild to moderate atopic dermatitis in non-immunocompromised patients 12 years of age or older who have failed to respond adequately to other topical prescription treatments or when those treatments are not advisable • Topical treatment of nonsegmental vitiligo in adult and pediatric patients ≥ 12 years of age

Drug	Indication(s)
tacrolimus	• 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 – 0.03% ointment approved for patients 2 years of age or older – 0.1% ointment approved for patients 16 years of age or older
Adbry (tralokinumab-ldrm)	• Treatment of moderate-to-severe atopic dermatitis in adult and pediatric patients 12 years of age and older whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable
Rinvoq (upadacitinib)	• Treatment of adults and pediatric patients 12 years of age or older with refractory, moderate to severe atopic dermatitis whose disease is not adequately controlled with other systemic drug products, including biologics, or when use of those therapies is not advisable

Medications

Brand Names	Generic Names	Dosage
Cibinqo	abrocitinib	50 mg, 100 mg, 200 mg tablets
Eucrisa	crisaborole	2% ointment
Ebglyss	lebrikizumab-lbkz	250 mg/2 mL pen and syringe
Nemluvio**	nemolizumab-ilto	30 mg pen
Elidel	pimecrolimus	1% cream
Zoryve	roflumilast	0.15% cream
Opzelura**	ruxolitinib	1.5% cream
	tacrolimus	0.03%, 0.1% ointment
Adbry	tralokinumab-ldrm	150 mg/mL prefilled syringe, 300 mg/2 mL autoinjector
Rinvoq**	upadacitinib	15 mg, 30 mg tablets

For requests for dupilumab (Dupixent) use the Dupixent criteria.

**For upadacitinib (Rinvoq) all other indications, use the Systemic Immunomodulator criteria.

**For ruxolitinib (Opzelura) for vitiligo see below Atopic Dermatitis criteria.

**For nemolizumab-ilto (Nemluvio) for prurigo nodularis see below Atopic Dermatitis criteria.

Criteria for Approval

Topical Therapy

1. FDA-approved indication and age; **AND**
2. Patient has a defined failure or contraindication or intolerance to a trial of topical corticosteroids. In general, a trial constitutes two weeks for high-potency topical corticosteroids (e.g., diflorasone diacetate) and four weeks for low-potency topical corticosteroids (e.g., hydrocortisone acetate); **AND**
3. Opzelura and Zoryve only: Patient has a defined failure or contraindication or intolerance to a trial of topical calcineurin inhibitors (e.g., pimecrolimus or tacrolimus) or topical phosphodiesterase-4 inhibitor (e.g., crisaborole).

Length of Approval: Two months

Renewal: Six months

Systemic Therapy

1. FDA-approved indication and age; **AND**
2. Prescriber is a dermatologist, immunologist, or allergist (or one has been consulted); **AND**
3. Patient has a defined failure, contraindication, or intolerance to a trial of topical corticosteroids. In general, a trial constitutes two weeks for high-potency topical corticosteroids (e.g., diflorasone diacetate) and four weeks for low-potency topical corticosteroids (e.g., hydrocortisone acetate); **AND**
4. Patient has a defined failure, contraindication, or intolerance to a trial of pimecrolimus **or** a trial of tacrolimus **or** a trial of Eucrisa (crisaborole). A trial constitutes at least one month of therapy; **AND**
5. Patient will not receive concurrent therapy with any other monoclonal antibody biologics (e.g., tezepelumab, omalizumab, mepolizumab, reslizumab, dupilumab).
6. **Nemluvio only**: Requires ongoing topical corticosteroid and/or topical calcineurin inhibitor therapy.

Non-Preferred drugs on the preferred drug list (PDL) require additional PA.

Criteria for Denial

1. Failure to meet criteria for approval; **OR**
2. Treatment of psoriasis; **OR**
3. Treatment of infected atopic dermatitis; **OR**
4. Treatment of Netherton's syndrome.

Other Indications

Prior authorization will be granted for the following approved FDA indications **and** must be prescribed by a dermatologist, immunologist, or allergist (or one has been consulted).

Brand Names	Generic Names	Indication
Nemluvio	nemolizumab-ilto	Treatment of adults with prurigo nodularis
Opzelura	ruxolitinib	Topical treatment of nonsegmental vitiligo in adult and pediatric patients ≥ 12 years of age

References

Available upon request

Revision History

Reviewed by	Reason for Review	Date Approved
Pharmacy and Therapeutic Committee	New	11/02/2006
Commissioner	New	11/16/2006
DUR Board	Review	10/25/2010
Commissioner	Approval	02/10/2011
DUR Board	Revision	10/24/2017
Commissioner	Approval	12/05/2017
DUR Board	Revision	03/12/2019
Commissioner Designee	Approval	04/05/2019
DUR Board	Revision	10/28/2019
Commissioner Designee	Approval	12/03/2019
DUR Board	Revision	06/30/2020
Commissioner Designee	Approval	08/07/2020
DUR Board	Revision	12/15/2020
Commissioner Designee	Approval	02/24/2021
DUR Board	Revision	06/02/2022
Commissioner Designee	Approval	07/12/2022
DUR Board	Revision	12/13/2022
Commissioner Designee	Approval	01/26/2023
DUR Board	Revision	06/19/2023

Reviewed by	Reason for Review	Date Approved
Commissioner Designee	Approval	06/29/2023
DUR Board	Revision	05/07/2024
Commissioner Designee	Approval	06/10/2024
DUR Board	Revision	10/15/2024
Commissioner Designee	Approval	11/21/2024
DUR Board	Revision	04/08/2025
Commissioner Designee	Approval	06/05/2025