

# Cigna National Preferred Formulary Coverage Policy



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Next Review Date... 1/1/2022

Coverage Policy Number ..... NPF160

## Drug Quantity Management – Per Days Fluocinonide Topical Products Duration Limit

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### Related Coverage Resources

#### INSTRUCTIONS FOR USE

The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

### NPF Coverage Policy

#### Drugs Affected

- fluocinonide cream 0.05%
- fluocinonide cream-emulsified base cream 0.05%
- fluocinonide gel 0.05%
- fluocinonide ointment 0.05%
- fluocinonide solution 0.05%
- fluocinonide cream 0.1% (Vanos®)

Table 1. Quantity Level Limits

Medication Name and Strength	Per Days Quantity Level Limit
fluocinonide cream 0.05% (generics) – 15grams tube, 30 grams tube, 60 grams tube and 120 grams tube.	A quantity of 120 grams for cream per 30 days

fluocinonide cream-emulsified base 0.05% (generics) – 15grams tube, 30 grams tube, 60 grams tube.	A quantity of 120 grams for cream-emulsified base per 30 days
fluocinonide ointment 0.05% (generics) –15grams tube, 30 grams tube, 60 grams tube.	A quantity of 120 grams ointment per 30 days
fluocinonide gel 0.05% (generics) –15grams tube, 30 grams tube, 60 grams tube.	A quantity of 120 grams for gel per 30
fluocinonide solution 0.05% (generics) – 20 ml 60 ml bottle	A quantity of 120 ml for solution per 30 days
fluocinonide cream 0.1% (Vanos® -Valeant, generics) – 30 grams tube, 60 grams tube and 120 grams tube.	A quantity of 120 grams for cream per 30 days

This is enough drug to cover 8% of the body surface area when applying two times daily for one month

### Criteria

#### **Cigna covers quantities as medically necessary when the following criteria are met:**

All approvals are provided for 12 months in duration unless otherwise noted below.

1. For individuals needing to treat greater than 8% of body surface area or administering more frequently than two times a day, an override of up to 180 grams per month can be allowed for cream, cream-emulsified base, ointment, or gel and 180 ml for solution.

### Conditions Not Covered

Any other exception is considered not medically necessary, including the following:

1. No overrides are recommended for use in compounded formulations.
2. No overrides are recommended for any other indications not listed in the prescribing information.

## Background

### **Overview**

Fluocinonide cream, cream-emulsified base, ointment, gel, and solution are indicated for the relief of the inflammatory and pruritic manifestations of corticosteroid-responsive dermatoses, including moderate-to-severe plaque psoriasis.

Moderate-to-severe psoriasis is typically defined as involvement of more than 5 to 10 percent of the body surface area (the entire palmar surface, including fingers, of one hand is approximately 1 percent of the body surface area) or involvement of the face, palm or sole, or disease that is otherwise disabling. Patients with more than 5 to 10 percent body surface area affected are generally candidates for phototherapy or systemic therapy, since application of topical agents to a large area is not usually practical or acceptable for most patients.

For coverage of additional quantities (for example, coverage of a larger surface area, more frequent administration), a coverage review is required. The objective of this program is to prevent stockpiling, misuse and/or overuse.

## References

1. Fluocinonide cream, cream-emulsified base, gel, ointment, 0.05% [prescribing information]. Hawthorne, NY: Taro Pharmaceuticals, November 2017.

2. Fluocinonide solution 0.05% [prescribing information]. Hawthorne, NY: Taro Pharmaceuticals, January 2016.
3. Vanos® 0.1% cream [prescribing information]. Scottsdale, AZ: Medicis, May 2017.
4. Nelson A, Miller A, Fleischer A, Balkrishnan R, Feldman S. How much of a topical agent should be prescribed for children of different sizes? J Derm Treat 2006; 17:224-228.
5. Long CC, Finlay AY. The finger-tip unit—a new practical measure. Clin Exp Dermatol 1991 Nov; 16(6):444-7.

## Last Revision Details

Annual Revision	Reviewed by Clinical Specialists. No change to criteria.	07/28/2020
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