



## Drug Coverage Policy

Effective Date .....04/01/2026  
Coverage Policy Number..... ST005  
Policy Title.... Topical Agents for Atopic  
Dermatitis Step Therapy Policy for  
Employer Plans

# Topical Agents for Atopic Dermatitis Step Therapy Policy for Employer Plans

- Eucrisa® (crisaborole 2% ointment – Pfizer)
- Zoryve® (roflumilast 0.05% and 0.15% cream - Arcutis)

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### **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. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment where appropriate and have discretion in making individual coverage determinations. Where coverage for care or services does not depend on specific circumstances, reimbursement will only be provided if a requested service(s) is submitted in accordance with the relevant criteria outlined in the applicable Coverage Policy, including covered diagnosis and/or procedure code(s). Reimbursement is not allowed for services when billed for conditions or diagnoses that are not covered under this Coverage Policy (see "Coding Information" below). When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted for services that are not accompanied by covered code(s) under the applicable Coverage Policy will be denied as not covered. 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.*

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## Overview

Tacrolimus ointment and pimecrolimus cream are topical calcineurin inhibitors that are indicated as *second-line therapy* for the short-term and non-continuous chronic treatment of **atopic dermatitis** in non-immunocompromised patients who have failed to respond adequately to other topical prescription treatments, or when those treatments are not advisable.<sup>1,2</sup> Tacrolimus ointment is indicated for moderate to severe atopic dermatitis while pimecrolimus cream is indicated for mild to moderate atopic dermatitis. Eucrisa and Zoryve cream, topical phosphodiesterase 4 inhibitors, are indicated for the topical treatment of mild to moderate **atopic dermatitis**.<sup>3,7</sup>

Tacrolimus 0.03% ointment and pimecrolimus cream are indicated for use in adults and children  $\geq$  2 years of age.<sup>1,2</sup> Although there are data documenting the tacrolimus 0.1% strength's safety and efficacy in children, this product is not approved for use in pediatric patients. Neither tacrolimus 0.03% ointment nor pimecrolimus cream are indicated for use in children  $<$  2 years of age; however, both agents have been studied in this patient population. Eucrisa is indicated for use in patients  $\geq$  3 months of age.<sup>3</sup> Zoryve 0.15% cream is indicated for use in patients  $\geq$  6 years of age and Zoryve 0.05% cream is indicated for use in patients 2 to 5 years of age.<sup>7</sup>

Topical corticosteroids are generally indicated for the relief of the inflammatory and pruritic manifestations of corticosteroid-responsive dermatoses.<sup>4</sup>

## Guidelines

The American Academy of Dermatology (AAD) Guidelines of Care for the Management of Atopic Dermatitis in Adults with Topical Therapies (2023) recommend the use of topical corticosteroids and note that these products are commonly used as first-line topical treatment as they suppress the release of proinflammatory cytokines and target a variety of immune cells.<sup>5</sup> Topical calcineurin inhibitors (i.e., tacrolimus ointment and pimecrolimus cream) are noted to be a safe topical anti-inflammatory option, particularly if topical corticosteroid adverse events are of concern. Tacrolimus ointment is recommended for use in all adults with atopic dermatitis, while pimecrolimus cream is a recommended treatment option for patients with mild-to-moderate disease. Similarly, Eucrisa is a recommended treatment option for adults with mild-to-moderate atopic dermatitis. The AAD published a focused guideline update (2025) addressing several newer therapies.<sup>8</sup> These guidelines support the use of Zoryve 0.15% cream for adults with mild-to-moderate atopic dermatitis; the 0.05% strength is not addressed.

Recommendations for the management of pediatric patients have not been updated. However, AAD guidelines from 2014 make similar recommendations regarding the use of topical corticosteroids and topical calcineurin inhibitors in pediatric patients.<sup>6</sup> Eucrisa and Zoryve cream are not addressed.

## Coverage Policy

### POLICY STATEMENT

This program has been developed to encourage the use of a Step 1 Product prior to the use of a Step 2 Product. If the Step Therapy rule is not met for a Step 2 Product at the point of service, coverage will be determined by the Step Therapy criteria below. All approvals are provided for 1 year in duration. Meeting Step therapy Program Criteria does not satisfy any other prior authorization or medical necessity criteria requirements.

**Step 1:** generic pimecrolimus 1% cream, generic tacrolimus ointment (0.03% and 0.1% strengths), prescription topical corticosteroids (brand or generic)

**Step 2:** Eucrisa, Zoryve cream (0.05% and 0.15% strengths)

**Topical Agents for Atopic Dermatitis Medications are covered as medically necessary when ONE of the following criteria is met (1 or 2). Any other exception is considered not medically necessary.**

**CRITERIA**

- 1. If the patient has tried a Step 1 Product, approve a Step 2 Product.
- 2. If the patient is < 2 years of age, approve Eucrisa.

**References**

- 1. Elidel® cream [prescribing information]. Bridgewater, NJ: Bausch; September 2020.
- 2. Protopic® ointment [prescribing information]. Madison, NJ: LEO; February 2019.
- 3. Eucrisa® ointment [prescribing information]. New York, NY: Pfizer; September 2025.
- 4. Triamcinolone acetonide cream [prescribing information]. Hawthorne, NY: Taro; July 2025.
- 5. Sidbury R, Alikhan A, Bercovitch L, et al. Guidelines of care for the management of atopic dermatitis in adults with topical therapies. *J Am Acad Dermatol.* 2023;89(1):e1-e20.
- 6. Eichenfield LF, Tom WL, Berger TG, et al. Guidelines of care for the management of atopic dermatitis. Section 2: management and treatment of atopic dermatitis with topical therapies. *J Am Acad Dermatol.* 2014;71(1):116-132.
- 7. Zoryve® cream [prescribing information]. Westlake Village, CA: Arcutis; October 2025.
- 8. Davis DMR, Frazer-Green L, Alikhan A, et al. Focused update: guidelines of care for the management of atopic dermatitis in adults. *J Am Acad Dermatol.* 2025;93(3):745.e1-745.e7.

**Revision Details**

Type of Revision	Summary of Changes	Date
New	New policy.	04/01/2026

The policy effective date is in force until updated or retired.

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