Topical Doxepin Prior Authorization with Quantity Limit Program Summary

This program applies to Flex Closed, FlexRx Open, GenRx Open, Gen Closed, Medicaid, Health Insurance Marketplace, FocusRx and KeyRx formularies.

This is a FlexRx and GenRx standard prior authorization program.

The BCBS MN Step Therapy Supplement also applies to this program for all Commercial/HIM lines of business.

**FDA APPROVED INDICATIONS AND DOSAGE**

<table>
<thead>
<tr>
<th>Agent(s)</th>
<th>Indication(s)</th>
<th>Dosage &amp; Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Doxepin</strong></td>
<td>Short-term (up to 8 days) management of moderate pruritus in adult patients</td>
<td>A thin film of doxepin hydrochloride cream, 5% should be applied four times each day with at least a 3 to 4 hour interval between applications.</td>
</tr>
<tr>
<td>5% cream</td>
<td>with atopic dermatitis or lichen simplex chronicus.*</td>
<td>There are no data to establish the safety and effectiveness of doxepin hydrochloride cream, 5% when used for greater than 8 days. Chronic use beyond eight days may result in higher systemic levels and should be avoided. Use of doxepin hydrochloride cream, 5% for longer than 8 days may result in an increased likelihood of contact sensitization.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Drowsiness is significantly more common in patients applying doxepin cream to over 10% of their body surface area.</td>
</tr>
<tr>
<td><strong>Prudoxin™</strong></td>
<td>Short-term (up to 8 days) management of moderate pruritus in adult patients</td>
<td>A thin film of doxepin hydrochloride cream, 5% should be applied four times each day with at least a 3 to 4 hour interval between applications.</td>
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<td>with atopic dermatitis or lichen simplex chronicus.*</td>
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<td>cream 5%</td>
<td></td>
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</tr>
<tr>
<td>---------</td>
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</tr>
<tr>
<td><strong>Zonalon® (doxepin cream 5%)</strong></td>
<td>Short-term (up to 8 days) management of moderate pruritus in adult patients with atopic dermatitis or lichen simplex chronicus.*</td>
<td>A thin film of doxepin hydrochloride cream, 5% should be applied four times each day with at least a 3 to 4 hour interval between applications. There are no data to establish the safety and effectiveness of doxepin hydrochloride cream, 5% when used for greater than 8 days. Chronic use beyond eight days may result in higher systemic levels and should be avoided. Use of doxepin hydrochloride cream, 5% for longer than 8 days may result in an increased likelihood of contact sensitization. Drowsiness is significantly more common in patients applying doxepin cream to over 10% of their body surface area.</td>
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</table>

*Pediatric use is not recommended. There was a case of a 2.5 year old who developed somnolence, grand mal seizure, respiratory depression, ECG abnormalities, and coma after treatment with doxepin cream.

**CLINICAL RATIONALE**

**Atopic Dermatitis**

Atopic dermatitis is a chronic, pruritic, inflammatory skin disease. Clinical features include skin dryness, erythema, oozing and crusting, and lichenification. Pruritus is responsible for much of the disease burden for patients. The goals of treatment are to reduce symptoms of pruritus and dermatitis, prevent exacerbations, and minimize therapeutic risks. Recommended topical therapy for atopic dermatitis includes topical corticosteroids, intralesional corticosteroids, as well as topical calcineurin inhibitors. While topical doxepin does provide short-term decrease in pruritus, it is not recommended for atopic dermatitis by the American Academy of Dermatology Association due to the risk of absorption and contact dermatitis. UptoDate lists topical doxepin as an option for treating atopic dermatitis pruritus after sedating and non-sedating antihistamines have failed.

**Lichen Simplex Chronicus**

Lichen simplex chronicus is a secondary skin disorder that results from excessive scratching. Typically, lichenified plaques and excoriations are present. Patients typically complain of intense pruritus in the affected areas. The treatment of lichen simplex chronicus centers on the discontinuation of the itch/scratch cycle. Topical corticosteroids and intralesional corticosteroids are commonly used therapies. Oral antihistamines is a systemic option for less localized pruritus. Doxepin is an option for local treatment of pruritus.

**Safety**

Doxepin cream is contraindicated in the following:
- Patients with untreated narrow angle glaucoma or a tendency to urinary retention.
- Individuals who have shown previous sensitivity to any of its components.

Prudoxin is contraindicated in the following:
- Patients with untreated narrow angle glaucoma or a tendency to urinary retention.
- Individuals who have shown previous sensitivity to any of its components.

Zonalon is contraindicated in the following:
• Patients with untreated narrow angle glaucoma or a tendency to urinary retention.
• Individuals who have shown previous sensitivity to any of its components.

REFERENCES
Topical Doxepin Prior Authorization with Quantity Limit

OBJECTIVE
The intent of the Topical Doxepin Prior Authorization (PA) and Quantity Limit (QL) program is to appropriately select patients for therapy according to product labeling and/or clinical guidelines and according to dosing recommended in product labeling. For the diagnosis of moderate pruritus associated with atopic dermatitis, the program requires the patient to have tried a topical corticosteroid, topical calcineurin inhibitor, intralesional corticosteroid, or oral antihistamine; or the patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to topical corticosteroids, topical calcineurin inhibitors, intralesional corticosteroids, and oral antihistamines. For the diagnosis of moderate pruritus associated with lichen simplex chronicus, the program requires the patient to have tried a topical corticosteroid, intralesional corticosteroid, or oral antihistamine; or the patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to topical corticosteroids, intralesional corticosteroids, and oral antihistamines. The program will not allow approval for patients who have an FDA labeled contraindication to the requested agent, nor will it allow for the use of more than one targeted agent at a time, nor will it allow for durations longer than 8 days for a single course of therapy. The program will approve for doses within the set limit. Doses above the set limit will be approved if the prescriber has submitted documentation in support of therapy with a higher dose for the intended diagnosis. Requests will be reviewed when patient specific documentation is provided.

TARGET AGENTS
Doxepin 5% cream
Prudoxin (doxepin 5% cream)
Zonalon (doxepin 5% cream)

PRIOR AUTHORIZATION TARGET AND QUANTITY LIMIT

<table>
<thead>
<tr>
<th>Brand (generic)</th>
<th>GPI</th>
<th>Multisource Code</th>
<th>Quantity Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doxepin 5% cream</td>
<td>90220015103710</td>
<td>M, N, O, Y</td>
<td>45 g every 30 days²</td>
</tr>
<tr>
<td>Prudoxin 5% cream</td>
<td>90220015103710</td>
<td>M, N, O, Y</td>
<td>45 g every 30 days²</td>
</tr>
<tr>
<td>Zonalon 5% cream</td>
<td>90220015103710</td>
<td>M, N, O, Y</td>
<td>45 g every 30 days²</td>
</tr>
</tbody>
</table>

² – quantity limit is cumulative across agents

PRIOR AUTHORIZATION AND QUANTITY LIMIT CRITERIA FOR APPROVAL
Target Agents will be approved when ALL of the following are met:
1. The patient is an adult
   AND
2. ONE of the following:
   a. The patient has a diagnosis of moderate pruritus associated with atopic dermatitis AND ONE of the following:
      i. The patient’s medication history includes the use of a topical corticosteroid, intralesional corticosteroid, topical calcineurin inhibitor, or oral antihistamine in the past 90 days OR
      ii. The patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to topical corticosteroids, intralesional corticosteroids, topical calcineurin inhibitors, AND oral antihistamines OR
   b. The patient has a diagnosis of moderate pruritus associated with lichen simplex chronicus AND ONE of the following:
i. The patient’s medication history includes the use of a topical corticosteroid, intralesional corticosteroid, or oral antihistamine in the past 90 days

OR

ii. The patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to topical corticosteroids, intralesional corticosteroids, AND oral antihistamines

OR

c. The patient has another FDA approved indication for the requested agent AND

3. ONE of the following:
   a. The patient is not concurrently using another topical doxepin agent OR
   b. The patient will discontinue the other topical doxepin agent prior to starting therapy with the requested agent AND

4. The patient has not already received 8 days of therapy with a topical doxepin agent for the current course of therapy AND

5. The patient does NOT have any FDA labeled contraindication(s) to the requested agent AND

6. ONE of the following:
   a. The requested quantity (dose) is NOT greater than the program quantity limit OR
   b. BOTH of the following:
      i. The requested quantity (dose) is greater than the program quantity limit AND
      ii. The prescriber has submitted documentation in support of therapy with a higher dose for the intended diagnosis (must be reviewed by the Clinical Review pharmacist)

Length of Approval: 12 months
Step Therapy Supplement

This program applies to FlexRx Closed, FlexRx Open, GenRx Closed, GenRx Open, Health Insurance Marketplace, FocusRx and KeyRx formularies.

Please note, this does not include or apply to quantity limit questions.

STEP THERAPY SUPPLEMENT

OBJECTIVE

The intent of the Step Therapy Supplement is to provide additional questions, to ensure compliance to MN Statute 62Q.184. These questions will apply if the step therapy component within a Prior Authorization or Step Therapy program is not able to be approved.

CONDITIONS FOR APPROVAL

The requested agent will be approved when ONE of the following are met:

1. The patient is currently being treated with the requested agent as indicated by ALL of the following:
   a. A statement by the prescriber that the patient is currently taking the requested agent
   AND
   b. A statement by the prescriber that the patient is currently receiving a positive therapeutic outcome on requested agent
   AND
   c. The prescriber states that a change in therapy is expected to be ineffective or cause harm

   OR

2. The patient’s medication history include the required prerequisite/preferred agent(s) as indicated by:
   a. Evidence of a paid claim(s) within the past 999 days
   OR
   b. The prescriber has stated that the patient has tried the required prerequisite/preferred agent(s) in the past 999 days AND the required prerequisite/preferred agent(s) was discontinued due to lack of effectiveness or an adverse event

   OR

3. The prescriber has provided documentation that the required prerequisite/preferred agent(s) cannot be used due to a documented medical condition or comorbid condition that is likely to cause an adverse reaction, decrease ability of the patient to achieve or maintain reasonable functional ability in performing daily activities or cause physical or mental harm

Length of Approval: As per program specific criteria