

PHARMACY / MEDICAL POLICY – 5.01.628


Pharmacologic Treatment of Atopic Dermatitis

Effective Date: Apr. 1, 2025
Last Revised: Mar. 11, 2025
Replaces: N/A

RELATED MEDICAL POLICIES:
5.01.575 Dupixent (dupilumab)

Select a hyperlink below to be directed to that section.

[POLICY CRITERIA](#) | [DOCUMENTATION REQUIREMENTS](#) | [CODING](#)
[RELATED INFORMATION](#) | [EVIDENCE REVIEW](#) | [REFERENCES](#) | [HISTORY](#)

 Clicking this icon returns you to the hyperlinks menu above.

Introduction

Atopic dermatitis (AD) is a chronic skin condition. (Chronic means the condition lasts a long time or returns repeatedly.) Symptoms of AD include weeping, oozing plaques, itchy skin, raised red rashes or rashes that appear to have small blisters, dry and flaky skin, and increased allergic reaction. A person with AD may also have a personal or family history of hay fever or other skin conditions. The itchy skin can be triggered by a number of situations. These include heat and perspiration, wool, emotional stress, specific foods, and house dust mites. Scratching and rubbing irritate the skin and increase inflammation, which leads to more itching. Medications called topical corticosteroids and topical calcineurin inhibitors are often successful in treating AD. When a person does not respond to topical corticosteroids and topical calcineurin inhibitors there are other medications that can be tried for AD. This policy describes when these medications may be considered medically necessary to treat AD.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.

Policy Coverage Criteria

Drug	Medical Necessity
Aryl Hydrocarbon Receptor (AhR) Agonist	
Vtama (tapinarof) topical	<p>Vtama (tapinarof) may be considered medically necessary for the treatment of atopic dermatitis when:</p> <ul style="list-style-type: none"> The individual is aged 2 years or older <p>AND</p> <ul style="list-style-type: none"> Has had an inadequate response or intolerance to one topical corticosteroid medication <ul style="list-style-type: none"> Exception: this may be granted for face or genital involvement <p>AND</p> <ul style="list-style-type: none"> Has had an inadequate response or intolerance to one topical calcineurin inhibitor medication, such as pimecrolimus or tacrolimus
Calcineurin Inhibitors	
<ul style="list-style-type: none"> Elidel (pimecrolimus) topical Protopic (tacrolimus) topical 	<p>Elidel (pimecrolimus) and Protopic (tacrolimus) may be considered medically necessary for the treatment of atopic dermatitis when:</p> <ul style="list-style-type: none"> The individual is aged 2 years or older <p>AND</p> <ul style="list-style-type: none"> Has had an inadequate response or intolerance to one topical corticosteroid medication <ul style="list-style-type: none"> Exception: this may be granted for face or genital involvement <p>AND</p> <ul style="list-style-type: none"> Has tried both generic pimecrolimus and generic tacrolimus first and had an inadequate response or intolerance to generic pimecrolimus and generic tacrolimus (documentation required)
Interleukin-4 Receptor Alpha Antagonist	
Dupixent (dupilumab) SC	See policy 5.01.575 Dupixent (dupilumab)
Interleukin-13 Antagonist	
Adbry (tralokinumab-ldrm) SC	<p>Adbry (tralokinumab-ldrm) may be considered medically necessary for the treatment of moderate to severe atopic dermatitis when all the following criteria are met:</p> <ul style="list-style-type: none"> The individual is aged 12 years or older <p>AND</p>



Drug	Medical Necessity
	<ul style="list-style-type: none"> • Has a diagnosis of atopic dermatitis involving $\geq 10\%$ of his or her body surface area (BSA) <ul style="list-style-type: none"> ○ Exception: this may be granted when ANY of the following are true: <ul style="list-style-type: none"> ▪ There is extensive recalcitrant facial involvement <p>OR</p> <ul style="list-style-type: none"> ▪ There is pustular involvement of the hands and feet <p>OR</p> <ul style="list-style-type: none"> ▪ There is genital involvement which interferes with normal sexual function <p>AND</p> <ul style="list-style-type: none"> • Has had an inadequate response or intolerance to one topical calcineurin inhibitor medication, such as pimecrolimus or tacrolimus <p>AND</p> <ul style="list-style-type: none"> • Has had an inadequate response or intolerance to one topical corticosteroid medication of high potency, such as: betamethasone dipropionate, mometasone furoate, fluocinonide, or clobetasol propionate <ul style="list-style-type: none"> ○ Exception: this may be granted for face or genital involvement <p>AND</p> <ul style="list-style-type: none"> • Medication is prescribed by or in consultation with an allergist, immunologist, or dermatologist <p>AND</p> <ul style="list-style-type: none"> • The maintenance dose prescribed is 300 mg given every other week
<p>Ebglyss (lebrikizumab-lbkz) SC</p>	<p>Ebglyss (lebrikizumab-lbkz) may be considered medically necessary for the treatment of moderate to severe atopic dermatitis when all the following criteria are met:</p> <ul style="list-style-type: none"> • The individual is aged 12 years or older <p>AND</p> <ul style="list-style-type: none"> • Has a diagnosis of atopic dermatitis involving $\geq 10\%$ of his or her body surface area (BSA) <ul style="list-style-type: none"> ○ Exception: this may be granted when ANY of the following are true: <ul style="list-style-type: none"> ▪ There is extensive recalcitrant facial involvement



Drug	Medical Necessity
	<p>OR</p> <ul style="list-style-type: none"> ▪ There is pustular involvement of the hands and feet <p>OR</p> <ul style="list-style-type: none"> ▪ There is genital involvement which interferes with normal sexual function <p>AND</p> <ul style="list-style-type: none"> • Has had an inadequate response or intolerance to one topical calcineurin inhibitor medication, such as pimecrolimus or tacrolimus <p>AND</p> <ul style="list-style-type: none"> • Has had an inadequate response or intolerance to one topical corticosteroid medication of high potency, such as: betamethasone dipropionate, mometasone furoate, fluocinonide, or clobetasol propionate <ul style="list-style-type: none"> ○ Exception: this may be granted for face or genital involvement <p>AND</p> <ul style="list-style-type: none"> • Medication is prescribed by or in consultation with an allergist, immunologist, or dermatologist <p>AND</p> <ul style="list-style-type: none"> • The maintenance dose prescribed is 250 mg given every 4 weeks
Janus Kinase (JAK) Inhibitors	
Cibinqo (abrocitinib) oral	<p>Cibinqo (abrocitinib) may be considered medically necessary for the treatment of moderate to severe atopic dermatitis when all the following criteria are met:</p> <ul style="list-style-type: none"> • The individual is aged 12 years or older <p>AND</p> <ul style="list-style-type: none"> • Has a diagnosis of atopic dermatitis involving $\geq 10\%$ of his or her body surface area (BSA) <ul style="list-style-type: none"> ○ Exception: this may be granted when ANY of the following are true: <ul style="list-style-type: none"> ▪ There is extensive recalcitrant facial involvement <p>OR</p> <ul style="list-style-type: none"> ▪ There is pustular involvement of the hands and feet <p>OR</p>



Drug	Medical Necessity
	<ul style="list-style-type: none"> ▪ There is genital involvement which interferes with normal sexual function <p>AND</p> <ul style="list-style-type: none"> • Has had an inadequate response or intolerance to one topical calcineurin inhibitor medication, such as pimecrolimus or tacrolimus <p>AND</p> <ul style="list-style-type: none"> • Has had an inadequate response or intolerance to one topical corticosteroid medication of high potency, such as: betamethasone dipropionate, mometasone furoate, fluocinonide, or clobetasol propionate <ul style="list-style-type: none"> ○ Exception: this may be granted for face or genital involvement <p>AND</p> <ul style="list-style-type: none"> • Has had an inadequate response or intolerance to one traditional systemic therapy (e.g., methotrexate, azathioprine, cyclosporine, mycophenolate mofetil) <ul style="list-style-type: none"> ○ Exception: an individual who has already tried Adbry (tralokinumab-ldrm) or Dupixent (dupilumab) is not required to “step back” and try a traditional systemic agent for atopic dermatitis <p>AND</p> <ul style="list-style-type: none"> • Medication is prescribed by or in consultation with an allergist, immunologist, or dermatologist <p>AND</p> <ul style="list-style-type: none"> • The maintenance dose prescribed is 200 mg once daily or less
<p>Opzelura (ruxolitinib) topical</p>	<p>Opzelura (ruxolitinib) may be considered medically necessary for the topical, short-term, and non-continuous chronic treatment of mild to moderate atopic dermatitis when all the following criteria are met:</p> <ul style="list-style-type: none"> • The individual is aged 12 years or older <p>AND</p> <ul style="list-style-type: none"> • Is not immunocompromised <p>AND</p> <ul style="list-style-type: none"> • Has had an inadequate response or intolerance to one topical corticosteroid medication



Drug	Medical Necessity
	<ul style="list-style-type: none"> ○ Exception: this may be granted for face or genital involvement <p>AND</p> <ul style="list-style-type: none"> • Has had an inadequate response or intolerance to one topical calcineurin inhibitor medication, such as pimecrolimus or tacrolimus <p>Use of Opzelura (ruxolitinib) for the treatment of vitiligo is considered cosmetic.</p>
Rinvoq (upadacitinib) oral	<p>Rinvoq (upadacitinib) may be considered medically necessary for the treatment of moderate to severe atopic dermatitis when all the following criteria are met:</p> <ul style="list-style-type: none"> • The individual is aged 12 years or older <p>AND</p> <ul style="list-style-type: none"> • Has a diagnosis of atopic dermatitis involving ≥10% of his or her body surface area (BSA) <ul style="list-style-type: none"> ○ Exception: this may be granted when ANY of the following are true: <ul style="list-style-type: none"> ▪ There is extensive recalcitrant facial involvement <p>OR</p> <ul style="list-style-type: none"> ▪ There is pustular involvement of the hands and feet <p>OR</p> <ul style="list-style-type: none"> ▪ There is genital involvement which interferes with normal sexual function <p>AND</p> <ul style="list-style-type: none"> • Has had an inadequate response or intolerance to one topical calcineurin inhibitor medication, such as pimecrolimus or tacrolimus <p>AND</p> <ul style="list-style-type: none"> • Has had an inadequate response or intolerance to one topical corticosteroid medication of high potency, such as: betamethasone dipropionate, mometasone furoate, fluocinonide, or clobetasol propionate <ul style="list-style-type: none"> ○ Exception: this may be granted for face or genital involvement <p>AND</p>



Drug	Medical Necessity
	<ul style="list-style-type: none"> • Has had an inadequate response or intolerance to one traditional systemic therapy (e.g., methotrexate, azathioprine, cyclosporine, mycophenolate mofetil) <ul style="list-style-type: none"> ○ Exception: An individual who has already tried or Adbry (tralokinumab-ldrm) or Dupixent (dupilumab) is not required to “step back” and try a traditional systemic agent for atopic dermatitis <p>AND</p> <ul style="list-style-type: none"> • Medication is prescribed by or in consultation with an allergist, immunologist, or dermatologist <p>AND</p> <ul style="list-style-type: none"> • The maintenance dose prescribed is 30 mg once daily or less
Phosphodiesterase 4 Inhibitor	
<p>Eucrisa (crisaborole) topical</p>	<p>Eucrisa (crisaborole) may be considered medically necessary for the treatment of atopic dermatitis when all the following criteria are met:</p> <ul style="list-style-type: none"> • The individual is aged 3 months or older <p>AND</p> <ul style="list-style-type: none"> • Has had an inadequate response or intolerance to one topical corticosteroid medication <ul style="list-style-type: none"> ○ Exception: this may be granted for face or genital involvement <p>AND</p> <ul style="list-style-type: none"> • For individuals aged 2 years and older, an inadequate response or intolerance to one topical calcineurin inhibitor medication, such as pimecrolimus or tacrolimus
<p>Zoryve (roflumilast) 0.15% cream topical</p>	<p>Zoryve (roflumilast) 0.15% cream may be considered medically necessary for the treatment of atopic dermatitis when all the following criteria are met:</p> <ul style="list-style-type: none"> • The individual is aged 6 years or older <p>AND</p> <ul style="list-style-type: none"> • Has had an inadequate response or intolerance to one topical corticosteroid medication <ul style="list-style-type: none"> ○ Exception: this may be granted for face or genital involvement <p>AND</p>



Drug	Medical Necessity
	<ul style="list-style-type: none"> Has had an inadequate response or intolerance to one topical calcineurin inhibitor medication, such as pimecrolimus or tacrolimus

Drug	Investigational
As listed	<p>The medications listed in this policy are subject to the product's US Food and Drug Administration (FDA) dosage and administration prescribing information.</p> <p>All other uses of Adbry (tralokinumab-ldrm), Cibinco (abrocitinib), Elidel (pimecrolimus), Eucrisa (crisaborole), Opzelura (ruxolitinib), Protopic (tacrolimus), and Zoryve (roflumilast) 0.15% cream for conditions not outlined in this policy are considered investigational.</p> <p>All other uses of Rinvoq (upadacitinib) for conditions not outlined in this policy, policy 5.01.550, policy 5.01.563, or policy 5.01.645 are considered investigational.</p> <p>All other uses of Vtama (tapinarof) for conditions not outlined in this policy or policy 5.01.629 are considered investigational.</p>

Drug	Not Medically Necessary
As listed	All other uses of the drugs for approved conditions listed in this policy are considered not medically necessary.

Length of Approval	
Approval	Criteria
Initial authorization	Non-formulary exception reviews and all other reviews for all drugs listed in policy may be approved up to 12 months.
Re-authorization criteria	Non-formulary exception reviews and all other reviews for all drugs listed in policy may be approved up to 12 months as long as the drug-specific coverage criteria are met, and chart



Length of Approval

Approval	Criteria
	notes demonstrate that the individual continues to show a positive clinical response to therapy.

Documentation Requirements

The individual's medical records submitted for review for all conditions should document that medical necessity criteria are met. The record should include the following:

- Office visit notes that contain the diagnosis, relevant history, physical evaluation, and medication history

Coding

Code	Description
HCPCS	
J3590	Unclassified biologics (use to report: Adbry)

Note: CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). HCPCS codes, descriptions and materials are copyrighted by Centers for Medicare Services (CMS).

Related Information

Consideration of Age

Age limits specified in this policy are determined according to the FDA-approved indications.



Benefit Application

Pharmacy Benefit

Cibinqo (abrocitinib), Ebglyss (lebrikizumab-lbkz), Elidel (pimecrolimus), Eucrisa (crisaborole), Opzelura (ruxolitinib), Protopic (tacrolimus), Rinvoq (upadacitinib), Vtama (tapinarof), and Zoryve (roflumilast) 0.15% cream are managed through the pharmacy benefit.

Medical / Pharmacy Benefit

Adbry (tralokinumab-ldrm) is managed through both the pharmacy and medical benefit.

Comparison of Representative Topical Corticosteroid Preparations (classified according to the US system)

Potency group	Corticosteroid	Vehicle type/form	Trade names (United States)	Available strength(s), % (except as noted)
Super-high potency (group 1)	Betamethasone dipropionate, augmented	Gel, lotion, ointment (optimized)	Diprolene	0.05
	Clobetasol propionate	Cream, gel, ointment, solution (scalp)	Temovate	0.05
		Cream, emollient base	Temovate E	0.05
		Lotion, shampoo, spray aerosol	Clobex	0.05
		Foam aerosol	Olux-E, Tovet	0.05
		Solution (scalp)	Cormax	0.05
		Spray aerosol	Clobex	0.05
	Fluocinonide	Cream	Vanos	0.1
	Flurandrenolide	Tape (roll)	Cordran	4 mcg/cm ²
	Halobetasol propionate	Cream, lotion, ointment	Ultravate	0.05
	Amcinonide	Ointment	Cyclocort, Amcort	0.1



Potency group	Corticosteroid	Vehicle type/form	Trade names (United States)	Available strength(s), % (except as noted)
High potency (group 2)	Betamethasone dipropionate	Ointment	Diprosone	0.05
		Cream, augmented formulation (AF)	Diprolene AF	0.05
	Clobetasol propionate	Cream	Impoyz	0.025
	Desoximetasone	Cream, ointment, spray	Topicort	0.25
		Gel	Topicort	0.05
	Diflorasone diacetate	Ointment	ApexiCon, Florone	0.05
		Cream, emollient	ApexiCon E	0.05
	Fluocinonide	Cream, gel, ointment, solution	Lidex	0.05
	Halcinonide	Cream, ointment, solution	Halog	0.1
Halobetasol propionate	Lotion	Bryhali	0.01	
High potency (group 3)	Amcinonide	Cream	Cyclocort, Amcort	0.1
		Lotion	Amcort	0.1
	Betamethasone dipropionate	Cream, hydrophilic emollient	Diprosone	0.05
	Betamethasone valerate	Ointment	Valisone	0.1
		Foam	Luxiq	0.12
	Diflorasone diacetate	Cream	Florone	0.05
	Fluocinonide	Cream aqueous emollient	Lidex-E	0.05
	Fluticasone propionate	Ointment	Cutivate	0.005
	Mometasone furoate	Ointment	Elocon	0.1
Triamcinolone acetone*	Cream, ointment	Aristocort HP, Kenalog, Triderm	0.5	

*Only triamcinolone 0.5% is high potency.



Atopic Dermatitis

Atopic dermatitis (AD) is a chronic inflammatory, relapsing skin condition that primarily causes significant itching, which can result in decreased quality of life. In 2012, the prevalence of AD in the US included 16.5 million adults (7.2%), with 6.6 million (40%) of those diagnosed with moderate-to-severe disease. While it is difficult to characterize, as individuals are less likely to seek treatment as they age, incidence has increased 2- to 3-fold in industrialized nations since the 1970s; AD can occur at any age, with the highest incidence between 3 and 6 months.

AD is characterized by the inappropriate activation of type 2 T helper (Th2) cells and type 2 innate lymphoid (ILC2) cells, with a predominant increase in type 2 cytokines in the skin, including interleukin (IL)-13 and IL-4. Both cytokines are implicated in tissue inflammation and epidermal barrier dysfunction.

The American Academy of Dermatology (AAD) has issued guidelines for the treatment of AD. However, these guidelines were last updated in 2014. This AAD guideline currently recommends a stepwise approach to treatment, with avoidance of triggers, basic skin care, and moisturization as the cornerstone. Topical corticosteroids are recommended when good skin care and regular use of emollients has failed. Topical calcineurin inhibitors (TCIs) may also be used concurrently with topical corticosteroids or as a steroid-sparing therapy. In individuals with severe disease or failing topical agents, particularly in adults, systemic therapies including methotrexate (MTX), azathioprine, cyclosporine, and mycophenolate mofetil have also been used with success.

Adbry (tralokinumab-ldrm)

Tralokinumab is a fully human, immunoglobulin (Ig) G4 monoclonal antibody that specifically binds to the interleukin (IL)-13 cytokine preventing its interaction with its receptor and the subsequent downstream signaling. It is the first MAb to be approved with IL-13 target. Three phase 3 trials (ECZTRA 1, 2, and 3) have been conducted to assess the efficacy and safety of tralokinumab as monotherapy or in combination with TCS in individuals with moderate-to-severe AD.



The ECZTRA 1 study was a phase III, randomized, double-blinded, placebo-controlled study of tralokinumab monotherapy in individuals with moderate-to-severe AD. 802 individuals were randomized to receive an initial 16-week course of tralokinumab (n= 603) or placebo (n= 199). Individuals were rerandomized at week 16 for continuation treatment, then had a final safety follow-up 16 weeks after the last dose of study medication. At Week 16, more individuals who received tralokinumab achieved an IGA 0/1 compared to individuals who received placebo (15.8% vs 7.1%; difference 8.6%; 95% CI: 4.1, 13.1; P=0.002). At Week 16, more individuals who received tralokinumab achieved EASI75 compared to individuals who received placebo (25.0% vs 12.7%; difference 12.1%; 95% CI: 5.8, 16.4; P<0.001).

The ECZTRA 2 study was a phase III, randomized, double-blinded, placebo-controlled study of tralokinumab monotherapy in individuals with moderate-to-severe AD. 794 individuals were randomized to receive an initial 16-week course of tralokinumab (n= 593) or placebo (n= 201). Individuals were rerandomized at week 16 for continuation treatment, then had a final safety follow-up 16 weeks after the last dose of study medication. At Week 16, more individuals who received tralokinumab achieved an IGA 0/1 compared to individuals who received placebo (22.2% vs 10.9%; difference 11.1%; 95% CI: 5.8, 16.4; P,0.001). At Week 16, more individuals who received tralokinumab achieved EASI75 compared to individuals who received placebo (33.2% vs 11.4%; difference 21.6%; 95% CI: 15.8, 27.3; P,0.001).

The ECZTRA 3 study was a phase III, randomized, double-blinded, placebo-controlled study of tralokinumab in combination with TCS in individuals with moderate-to-severe AD. 380 individuals were randomized to receive an initial 16-week course of tralokinumab in combination with TCS as needed (n=253) or placebo in combination with TCS (n=127). Individuals were rerandomized at week 16 for continuation treatment, then had a final safety follow-up 16 weeks after the last dose of study medication. At Week 16, more individuals who received tralokinumab achieved an IGA 0/1 compared to individuals who received placebo (38.9% vs 26.2%; difference 12.4%; 95% CI: 2.9, 21.9; P=0.015). At Week 16, more individuals who received tralokinumab achieved EASI75 compared to individuals who received placebo (56.0% vs 35.7%; difference 20.2%; 95% CI: 9.8, 30.6; P<0.001).

Cibinqo (abrocitinib)

Abrocitinib is a Janus kinase (JAK) inhibitor that reversibly inhibits JAK1 by blocking the adenosine triphosphate (ATP) binding site. In a cell-free isolated enzyme assay, abrocitinib was selective for JAK1 over JAK2 (28-fold), JAK3 (>340-fold), and tyrosine kinase (TYK) 2 (43-fold), as well as the broader kinome. The relevance of inhibition of specific JAK enzymes to therapeutic



effectiveness is not currently known. Both the parent compound and the active metabolites inhibit JAK1 activity in vitro with similar levels of selectivity.

The efficacy of abrocitinib as monotherapy and in combination with background topical corticosteroids were evaluated in 3 randomized, double-blind, placebo-controlled trials [Trial-AD-1 (NCT03349060), Trial-AD-2 (NCT03575871), and Trial-AD-3 (NCT03720470)] in 1615 subjects 12 years of age and older (abrocitinib is not approved for use in pediatric individuals) with moderate-to-severe atopic dermatitis as defined by Investigator's Global Assessment (IGA) score ≥ 3 , Eczema Area and Severity Index (EASI) score ≥ 16 , body surface area (BSA) involvement $\geq 10\%$, and Peak Pruritus Numerical Rating Scale (PP-NRS) ≥ 4 at the baseline visit prior to randomization.

Overall, 53% of subjects were male, 69% of subjects were white, 64% of subjects had a baseline IGA score of 3 (moderate AD), and 36% of subjects had a baseline IGA score of 4 (severe AD). The baseline mean EASI score was 30. The baseline mean age was 36 years old with 8% of subjects 12 to less than 18 years old and 92% of subjects 18 years of age or older. Subjects in these trials were those who had inadequate response to previous topical therapy or were subjects for whom topical treatments were medically inadvisable, or who had received systemic therapies including dupilumab. In each of the trials, over 40% of subjects had prior exposure to systemic therapy. In Trial-AD-1 and Trial-AD-2, 6% of the subjects had received dupilumab, whereas prior use of dupilumab was not allowed in Trial-AD-3. Trial-AD-1, Trial-AD-2, and Trial-AD-3 assessed the co-primary endpoints of IGA and EASI-75 responses at Week 12.

In the abrocitinib monotherapy trials (Trial-AD-1 and Trial-AD-2), the proportion of subjects achieving PP-NRS4 at Week 2 (defined as an improvement of ≥ 4 points from baseline in PP-NRS) was higher in subjects treated with abrocitinib monotherapy 200 mg once daily (28% in Trial-AD-1 and 24% in Trial-AD-2) and 100 mg once daily (11% in both trials) compared to placebo (2% in both trials). A higher proportion of subjects in the CIBINQO monotherapy 100 mg or 200 mg once daily arm compared to placebo achieved improvement in itching at Week 12.

In the abrocitinib in combination with background topical corticosteroids (Trial-AD-3), the proportions of subjects achieving PP-NRS4 at Week 2 was higher in subjects treated with abrocitinib 200 mg once daily (30%) and 100 mg once daily (14%) in combination with background medicated topical therapies compared to placebo (8%).



Ebglyss (lebrikizumab-lbkz)

Ebglyss (lebrikizumab) is a monoclonal antibody targeting IL-13 that inhibits its signaling by preventing the formation of the IL-4R α -IL-13R α 1 heterodimer receptor signaling complex. The approval of Ebglyss was based on results from three Phase 3 studies: ADvocate1, ADvocate2, and ADhere. These trials evaluated the safety and efficacy of Ebglyss in individuals \geq 12 years of age with moderate to severe atopic dermatitis (AD) who had an inadequate response to topical medications and were candidates for systemic therapy. In the trials, Ebglyss (used as monotherapy or in combination with a topical corticosteroid) met the primary endpoint at Week 16, achieving an Investigator's Global Assessment (IGA) score of 0 (clear) or 1 (almost clear) skin. Key secondary endpoints were also met in the trials. The safety profile of Ebglyss during Weeks 16–52 of maintenance treatment was generally consistent with that observed through Week 16.

Additionally, Ebglyss 250 mg Q4W showed a similar safety profile to Ebglyss 250 mg Q2W during this same period. In the monotherapy trials through Week 16, the proportion of individuals who discontinued treatment due to adverse events (AEs) was 2.4% in the Ebglyss 250 mg Q2W group and 1.8% in the placebo group. In the ADhere trial through Week 16, the proportion of individuals who discontinued treatment due to AEs was 2.1% in the Ebglyss 250 mg Q2W + TCS group and 0% in the placebo + TCS group. The most common adverse reactions leading to discontinuation of Ebglyss versus placebo were conjunctivitis and keratitis (0.6% vs. 0.3%) and injection site reactions (0.2% vs. 0) in the monotherapy trials, and conjunctivitis (0.7% vs. 0) and injection site reactions (0.7% vs. 0) in the ADhere trial.

Eucrisa (crisaborole)

Crisaborole is a phosphodiesterase 4 (PDE-4) inhibitor. PDE-4 inhibition results in increased intracellular cyclic adenosine monophosphate (cAMP) levels. The specific mechanism(s) by which crisaborole exerts its therapeutic action for the treatment of atopic dermatitis is not well defined.

Two multicenter, randomized, double-blind, parallel-group, vehicle-controlled trials (Trials 1 and 2) treated a total of 1522 subjects 2 to 79 years of age (86.3% of subjects were 2 to 17 years of age) with a 5% to 95% treatable BSA. At baseline, 38.5% of the subjects had an Investigator's Static Global Assessment [ISGA] score of 2 (mild), and 61.5% had an ISGA score of 3 (moderate), in the overall assessment of atopic dermatitis (erythema, induration/papulation, and oozing/crusting) on a severity scale of 0 to 4.

In both trials, subjects were randomized 2:1 to receive crisaborole or vehicle applied twice daily for 28 days. The primary efficacy endpoint was the proportion of subjects at Day 29 who



achieved success, defined as an ISGA grade of Clear (score of 0) or Almost Clear (score of 1) with a 2-grade or greater improvement from baseline, comparing crisaborole-treated subjects to vehicle-treated subjects. In Trial 1 32.8% of crisaborole treated subjects vs. 25.4% of vehicle-treated subjects were considered a success in ISGA. In Trial 2 31.4% of crisaborole treated subjects vs. 18.0% of vehicle-treated subjects were considered a success in ISGA.

Opzelura (ruxolitinib)

Ruxolitinib, a Janus kinase (JAK) inhibitor, inhibits JAK1 and JAK2 which mediate the signaling of a number of cytokines and growth factors that are important for hematopoiesis and immune function. JAK signaling involves recruitment of STATs (signal transducers and activators of transcription) to cytokine receptors, activation and subsequent localization of STATs to the nucleus leading to modulation of gene expression. The relevance of inhibition of specific JAK enzymes to therapeutic effectiveness is not currently known.

The efficacy of ruxolitinib cream 1.5% twice daily (BID) has only been studied up to 8 weeks of double-blind (DB) treatment vs vehicle. Open label (OL), single-arm extensions of up to 52 weeks are ongoing. Two identical Phase 3 studies of good quality (TRuE-AD1 and -AD2) consistently support the efficacy of ruxolitinib cream 1.5% BID over vehicle in individuals ≥ 12 years with mild to moderate AD as measured by Investigator's Global Assessment (IGA) response (IGA score 0 [clear] or 1 [almost clear] and change from baseline of ≥ 2 points), EASI-75 response, and improvement in itching (≥ 4 -point improvement from baseline in itch numerical rating scale) at week 8.1 Long-term efficacy remains to be established. Two OL single-arm extensions of up to 52-weeks duration are ongoing. Efficacy for sensitive areas (e.g., face, genitals), in children, and in combination with other topicals or systemics also remain to be established.

In a moderate quality Phase 2 dose-ranging trial, various doses and application regimens of ruxolitinib cream were compared to vehicle and this study also had an active control arm (triamcinolone 0.1% BID) for the first four weeks of DB treatment. Estimating the efficacy outcome graphics suggests similar efficacy between ruxolitinib cream 1.5% BID and triamcinolone 0.1% BID at 2 and 4 weeks for the primary endpoint of percentage change from baseline in EASI score and secondary endpoint of IGA response because their 95% confidence intervals overlap. However, the study was not powered to detect differences in IGA or EASI response between these active treatments. No other directly comparative effectiveness evidence vs other therapeutic alternatives for mild to moderate disease was identified at time of review.



Rinvoq (upadacitinib)

Upadacitinib is a Janus kinase (JAK) inhibitor. JAKs are intracellular enzymes which transmit signals arising from cytokine or growth factor-receptor interactions on the cellular membrane to influence cellular processes of hematopoiesis and immune cell function. Within the signaling pathway, JAKs phosphorylate and activate signal transducers and activators of transcription (STATs) which modulate intracellular activity including gene expression. Upadacitinib modulates the signaling pathway at the point of JAKs, preventing the phosphorylation preventing the phosphorylation and activation of STATs. JAK enzymes transmit cytokine signaling through their pairing (e.g., JAK1/JAK2, JAK1/JAK3, JAK1/TYK2, JAK2/JAK2, JAK2/TYK2). In a cell-free isolated enzyme assay, upadacitinib had greater inhibitory potency at JAK1 and JAK2 relative to JAK3 and TYK2. In human leukocyte cellular assays, upadacitinib inhibited cytokine-induced STAT phosphorylation mediated by JAK1 and JAK1/JAK3 more potently than JAK2/JAK2 mediated STAT phosphorylation. However, the relevance of inhibition of specific JAK enzymes to therapeutic effectiveness is not currently known.

The efficacy of upadacitinib 15 mg and 30 mg once daily, was assessed in three Phase 3 randomized, double-blind, multicenter trials (AD-1, AD-2, AD-3; NCT03569293, NCT03607422, and NCT03568318, respectively) in a total of 2584 individuals (12 years of age and older). Upadacitinib was evaluated in 344 pediatric individuals and 2240 adult individuals with moderate to severe atopic dermatitis (AD) not adequately controlled by topical medication(s). Disease severity at baseline was defined by a validated Investigator's Global Assessment (vIGAAD) score ≥ 3 in the overall assessment of AD on a severity scale of 0 to 4, an Eczema Area and Severity Index (EASI) score ≥ 16 , a minimum body surface area (BSA) involvement of $\geq 10\%$, and weekly average Worst Pruritus Numerical Rating Scale (NRS) score ≥ 4 . Overall, 57% of the individuals were male and 69% were white. The mean age at baseline was 34 years (ranged from 12 to 75 years) and 13% of the individuals were 12 to less than 18 years. At baseline, 49% of individuals had a vIGA-AD score of 3 (moderate AD), and 51% of individuals had a vIGA-AD score of 4 (severe AD). The baseline mean EASI score was 29 and the baseline weekly average Worst Pruritus NRS score was 7. Approximately 52% of the individuals had prior exposure to systemic AD treatment.

In all three trials, individuals received upadacitinib once daily oral doses of 15 mg, 30 mg, or matching placebo for 16 weeks. In Trial AD-3, individuals also received upadacitinib or placebo with concomitant topical corticosteroids (TCS) for 16 weeks.

All three trials assessed the co-primary endpoints of the proportion of individuals with a vIGA-AD score of 0 (clear) or 1 (almost clear) with at least a 2-point improvement and the proportion of individuals with EASI-75 (improvement of at least 75% in EASI score from baseline) at Week



16. Secondary endpoints included EASI-90 and EASI-100 at Week 16, and the proportion of individuals with reduction in itch (≥ 4 -point improvement from baseline in the Worst Pruritus NRS) at Weeks 1, 4, and 16. In Trials AD-1 and AD-2, the proportion of individuals with reduction in pain (≥ 4 -point improvement in the Atopic Dermatitis Symptom Scale [ADerm-SS] Skin Pain NRS) from baseline to Week 16 was a secondary endpoint.

In the upadacitinib monotherapy trial AD-1 at week 16 the vIGA-AD 0/1 difference from placebo (95% CI) for upadacitinib 15 mg was 40% (33%, 46%) and for upadacitinib 30 mg was 54% (47%, 60%). The EASI-75 difference from placebo for upadacitinib 15 mg was 53% (46%, 60%) and for upadacitinib 30 mg was 63% (57%, 70%).

In the upadacitinib monotherapy trial AD-2 at week 16 the vIGA-AD 0/1 difference from placebo (95% CI) for upadacitinib 15 mg was 34% (28%, 40%) and for upadacitinib 30 mg was 47% (41%, 54%). The EASI-75 difference from placebo for upadacitinib 15 mg was 47% (40%, 54%) and for upadacitinib 30 mg was 60% (53%, 66%).

In the upadacitinib with concomitant TCS trial (AD-3) at week 16 the vIGA-AD 0/1 difference from placebo (95% CI) for upadacitinib 15 mg was 29% (22%, 35%) and for upadacitinib 30 mg was 48% (41%, 54%). The EASI-75 difference from placebo for upadacitinib 15 mg was 38% (31%, 45%) and for upadacitinib 30 mg was 51% (44%, 57%).

References

1. Wollenberg, A., Blauvelt, A., Guttman-Yassky, E., Worm, M., Lynde, C., Lacour, J. P., Spelman, L., Katoh, N., Saeki, H., Poulin, Y., Lesiak, A., Kircik, L., Cho, S. H., Herranz, P., Cork, M. J., Peris, K., Steffensen, L. A., Bang, B., Kuznetsova, A., Jensen, T. N., ... ECZTRA 1 and ECZTRA 2 study investigators (2021). Tralokinumab for moderate-to-severe atopic dermatitis: results from two 52-week, randomized, double-blind, multicentre, placebo-controlled phase III trials (ECZTRA 1 and ECZTRA 2). *The British journal of dermatology*, 184(3), 437–449. <https://doi-org.offcampus.lib.washington.edu/10.1111/bjd.19574>
2. Silverberg, J. I., Toth, D., Bieber, T., Alexis, A. F., Elewski, B. E., Pink, A. E., Hijnen, D., Jensen, T. N., Bang, B., Olsen, C. K., Kurbasic, A., Weidinger, S., & ECZTRA 3 study investigators (2021). Tralokinumab plus topical corticosteroids for the treatment of moderate-to-severe atopic dermatitis: results from the double-blind, randomized, multicentre, placebo-controlled phase III ECZTRA 3 trial. *The British journal of dermatology*, 184(3), 450–463. <https://doi-org.offcampus.lib.washington.edu/10.1111/bjd.19573>
3. Papp K, Szepietowski JC, Kircik L, et al. Efficacy and safety of ruxolitinib cream for the treatment of atopic dermatitis: results from two phase 3, randomized, double-blind studies. *J Am Acad Dermatol*. 2021 May 4:S0190-9622(21)00931-2. doi: 10.1016/j.jaad.2021.04.085. Online ahead of print.
4. Kim BS, Howell MD, Sun K, et al. Treatment of atopic dermatitis with ruxolitinib cream (JAK1/JAK2 inhibitor) or triamcinolone cream. *J Allergy Clin Immunol*. 2020;145:572-582.
5. Eichenfeld LF, Luger T, Papp K, et al. Topical agents for the treatment of atopic dermatitis. *J Drugs Dermatol*. 2020;19(1):50-64.



6. Leshem YA, Hajar T, Hanifin JM, Simpson EL. What the Eczema Area and Severity Index score tells us about the severity of atopic dermatitis: an interpretability study. *Br J Dermatol.* 2015;172(5):1353-7.
7. Avena-Woods C. Overview of atopic dermatitis. *Am J Manag Care.* 2017;23(8 Suppl):S115-S123.
8. Kapur S, Watson W, Carr S. Atopic dermatitis. *Allergy Asthma Clin Immunol.* 2018;14(Suppl 2):52. doi:10.1186/s13223-018-0281-6
9. National Eczema Association. Atopic Dermatitis 101. Available at: <https://nationaleczema.org/atopic-dermatitis-101/>. Accessed March 3, 2025.
10. Barbarot S, Auziere S, Gackari A, et al. Epidemiology of atopic dermatitis in adults: results from an international survey. *Allergy.* 2018;73(6): 1284-1293.
11. Silverberg JI, Simpson EL. Associations of childhood eczema severity: a US population-based study. *Dermatitis.* 2014;25(3):107-114.
12. Flohr C, Mann J. New insights into the epidemiology of childhood atopic dermatitis. *Allergy.* 2014;69(1):3-16.
13. Bickers DR, Lim HW, Margolis D, et al., American Academy of Dermatology Association, & Society for Investigative Dermatology. The burden of skin diseases: 2004 a joint project of the American Academy of Dermatology Association and the Society for Investigative Dermatology. *J Am Acad Dermatol.* 2005;55(3), 490-500.
14. Drucker AM, Wang AR, Li WQ, Severson E, Block JK, Qureshi AA. The Burden of Atopic Dermatitis: Summary of a Report for the National Eczema Association. *J Invest Dermatol.* 2017;137(1):26-30.
15. Boothe WD, Tarbox JA, Tarbox MB. Atopic dermatitis: pathophysiology. *Adv Exp Med Biol.* 2017;1027:21-37.
16. American Academy of Dermatology Association (AAD). Atopic Dermatitis Clinical Guideline. <https://www.aad.org/member/clinical-quality/guidelines/atopic-dermatitis>. Accessed March 3, 2025.
17. Adbry (tralokinumab-ldrm) [prescribing information]. Madison, NJ: Leo Pharma Inc.; Revised June 2024.
18. Cibinqo (abrocitinib) [prescribing information]. New York, NY: Pfizer Labs; Revised December 2023.
19. Elidel (pimecrolimus) [prescribing information]. Bridgewater, NJ: Valeant Pharmaceuticals North America LLC; Revised December 2017.
20. Eucrisa (crisaborole) [prescribing information]. New York, NY: Pfizer Labs; Revised April 2023.
21. Opzelura (ruxolitinib) [prescribing information]. Wilmington, DE: Incyte Corporation; Revised August 2024.
22. Protopic (tacrolimus) [prescribing information]. Madison, NJ: Leo Pharma Inc.; Revised February 2019.
23. Rinvoq (upadacitinib) [prescribing information]. North Chicago, IL: Abbvie Inc.; Revised April 2024.
24. Zoryve (roflumilast) cream [prescribing information]. Westlake Village, CA; Arcutis Biotherapeutics, Inc.; July 2024.
25. Ebglyss (lebrikizumab-lbkz) [prescribing information]. Indianapolis, IN; Eli Lilly and Company; November 2024.
26. Vtama (tapinarof) [prescribing information]. Long Beach, CA; Dermavant Sciences, Inc; December 2024.

History

Date	Comments
06/01/22	New policy, approved May 10, 2022, effective for dates of service on or after June 1, 2022. Added coverage criteria for Adbry (tralokinumab-ldrm), Cibinqo (abrocitinib),



Date	Comments
	Elidel (pimecrolimus), Eucrisa (crisaborole), Opzelura (ruxolitinib), Protopic (tacrolimus), and Rinvoq (upadacitinib) for the treatment of atopic dermatitis. Moved Elidel, Protopic, Eucrisa, and Opzelura from Policy 5.01.605 to Policy 5.01.628 with no changes to coverage criteria. Moved Adbry, Cibinqo, and Rinvoq from Policy 5.01.550 to Policy 5.01.628 with no changes to coverage criteria.
05/01/23	Annual Review, approved April 19, 2023. Reviewed prescribing information and conducted literature search. Updated age requirement for Cibinqo (abrocitinib) from 18 years and older to 12 years and older. Added note to indicate that use of ruxolitinib for vitiligo is considered cosmetic and not covered by this policy. Changed the wording from "patient" to "individual" throughout the policy for standardization.
04/01/24	Annual Review, approved March 25, 2024. Updated age requirement for Adbry (tralokinumab-ldrm) from 18 years and older to 12 years and older.
09/01/24	Interim Review, approved August 13, 2024. Added coverage criteria for Zoryve (roflumilast) 0.15% cream.
12/01/24	Interim Review, approved November 12, 2024. Added coverage criteria for Ebglyss (lebrikizumab-lbkz).
04/01/25	Annual Review, approved March 11, 2025. Clarified that non-formulary exception review authorizations for all drugs listed in this policy may be approved up to 12 months. Clarified that the medications listed in this policy are subject to the product's FDA dosage and administration prescribing information. Added coverage criteria for Vtama (tapinarof) for the treatment of certain individuals with atopic dermatitis.

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. The Company adopts policies after careful review of published peer-reviewed scientific literature, national guidelines and local standards of practice. Since medical technology is constantly changing, the Company reserves the right to review and update policies as appropriate. Member contracts differ in their benefits. Always consult the member benefit booklet or contact a member service representative to determine coverage for a specific medical service or supply. CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). ©2025 Premera All Rights Reserved.

Scope: Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.

