Topical Anti-Inflammatories

Description

Alcortin A* (iodoquinol and hydrocortisone), Novacort* (hydrocortisone and pramoxine)

*Prior authorization for the brand formulation applies only to formulary exceptions due to being a non-covered medication.

Background

Alcortin A and Novacort are both corticosteroid containing products with anti-inflammatory and antipruritic effects that are used topically to decrease symptoms. Pruritus is a condition characterized as an itching sensation of the skin triggered by many chemical mediators (1-3).

Regulatory Status

FDA-approved indications:

Alcortin A - Based on a review of a related drug by the National Research Council and subsequent FDA classification for that drug, the indications are as follows: “Possibly” Effective: Contact or atopic dermatitis; impetiginized eczema; nummular eczema; endogenous chronic infectious dermatitis; stasis dermatitis; pyoderma; nuchal eczema and chronic eczematosid otitis externa; acne urticata; localized or disseminated neurodermatitis; lichen simplex chronicus; anogenital pruritus (vulvae, scroti, ani); folliculitis; bacterial dermatoses; mycotic dermatoses such as tinea (capitis, cruris, corporis, pedis); moniliasis; intertrigo (3).

Novacort contains an antipruritic and anti-inflammatory with an anesthetic agent as well as aloe polysaccharides indicated for the topical treatment of pruritic and inflammatory presentations of dermatoses (2).
Safety and effectiveness of Alcortin A in patients under the age of 12 have not been established (3).

**Related policies**
Fluticasone powder, Mometasone powder

**Policy**

*This policy statement applies to clinical review performed for pre-service (Prior Approval, Precertification, Advanced Benefit Determination, etc.) and/or post-service claims.*

Alcortin A may be considered **medically necessary** in patients 12 years of age or older with inflammatory or pruritic dermatoses and inadequate treatment response, intolerance, or contraindication to two of the following legend medications: hydrocortisone 1% (generic), silver nitrate, pramoxine /hydrocortisone (generic) and iodoquinol /hydrocortisone (generic); no dual therapy between Alcortin A and Novacort.

Novacort may be considered **medically necessary** in patients 2 years of age or older with inflammatory or pruritic dermatoses and inadequate treatment response, intolerance, or contraindication to two of the following legend medications: hydrocortisone 1% (generic), silver nitrate, pramoxine /hydrocortisone (generic) and iodoquinol /hydrocortisone (generic); no dual therapy between Alcortin A and Novacort.

Alcortin A is considered **investigational** in patients less than 12 years and for all other indications.

Novacort are considered **investigational** in patients less than 2 years and for all other indications.

**Prior-Approval Requirements**

**Alcortin A**

- **Age**: 12 years of age or older

**Novacort**

- **Age**: 2 years of age or older

**Diagnosis**
Patient must have the following:
Inflammatory or pruritic dermatoses (i.e. eczema, acne urticata, anogenital pruritus, diaper rash)

AND submission of medical records (e.g. chart notes, laboratory values) documenting ALL of the following:
1. NO dual therapy between Alcortin A and Novacort
2. Inadequate treatment response, intolerance, or contraindication to TWO of the following legend medications:
   a. Hydrocortisone 1% (generic)
   b. Silver Nitrate
   c. Pramoxine / hydrocortisone (generic)
   d. Iodoquinol/hydrocortisone (generic)

All approved requests are subject to review by a clinical specialist for final validation and coverage determination once all required documentation has been received. Current utilization, including samples, does not guarantee approval of coverage.

Prior – Approval Renewal Requirements

Alcortin A

Age 12 years of age or older

Novacort

Age 2 years of age or older

Diagnosis

Patient must have the following:
Inflammatory or pruritic dermatoses (i.e. eczema, acne urticata, anogenital pruritus, diaper rash)

AND submission of medical records (e.g. chart notes, laboratory values) documenting ALL of the following:
1. Improvement in symptoms
2. NO dual therapy between Alcortin A and Novacort
All approved requests are subject to review by a clinical specialist for final validation and coverage determination once all required documentation has been received. Current utilization, including samples, does not guarantee approval of coverage.

### Policy Guidelines

#### Pre - PA Allowance

None

#### Prior - Approval Limits

**Duration**  
3 months

#### Prior – Approval *Renewal* Limits

Same as above

### Rationale

**Summary**

Alcortin A and Novacort are corticosteroid containing products with anti-inflammatory and antipruritic effects that are used to treat corticosteroid-sensitive dermatoses (1-3).

Prior approval is required to ensure the safe, clinically appropriate, and cost effective use of Alcortin A and Novacort while maintaining optimal therapeutic outcomes.

### References


### Policy History

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<td>October 2016</td>
<td>Addition to PA</td>
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<td>December 2016</td>
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<tr>
<td>January 2017</td>
<td>Removal of Aloquin</td>
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<td>September 2017</td>
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<td>September 2018</td>
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<tr>
<td>February 2019</td>
<td>Addition of statement to Alcortin-A: *Prior authorization for the brand formulation applies only to formulary exceptions due to being a non-covered medication.</td>
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<tr>
<td>March 2019</td>
<td>Annual review</td>
</tr>
<tr>
<td>December 2019</td>
<td>Annual review. Moved Novacort to MFE with PA only</td>
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**Keywords**

This policy was approved by the FEP® Pharmacy and Medical Policy Committee on December 6, 2019 and is effective on January 1, 2020.