MEDICAL MUTUAL®

Drug Policy

Policy:	**Topical Antibiotics Step Therapy**	**Annual Review Date:** **09/19/2024**
Impacted Drugs:	**Altabax (repatamulin ointment)** **Bactroban (mupirocin cream)** **Centany (mupirocin ointment)** **Centany AT (mupirocin ointment)** **Generic mupirocin cream** **Xepi (ozenoxacin cream)**	**Last Revised Date:** **09/19/2024**

OVERVIEW

Altabax is indicated for use in adults and pediatric patients aged 9 months and older for the topical treatment of impetigo due to *Staphylococcus aureus* (methicillin-susceptible isolates only) or *Streptococcus pyogenes*. Centany/mupirocin ointment are indicated for the topical treatment of impetigo due to *S. aureus* and *S. pyogenes*.. Centany/mupirocin ointment can be used in children ≥ 2 months of age. Mupirocin cream is indicated for the treatment of secondarily infected traumatic skin lesions (up to 10 cm in length or 100 cm^2 in area) due to susceptible isolates of *S. aureus* and *S. pyogenes*. Mupirocin cream can be used in patients ≥ 3 months of age. Xepi, a topical quinolone antimicrobial, is indicated for the topical treatment of impetigo due to *S. aureus* or *S. pyogenes* in adults and pediatric patients ≥ 2 months of age.

POLICY STATEMENT

A preferred step therapy program has been developed to encourage the use of a preferred product prior to the use of a non-preferred product. If the preferred step therapy rule is not met for a non-preferred product at the point of service, coverage will be determined by the preferred step therapy criteria below. All approvals are provided for 12 months in duration.

Automation: A patient with a history of one Step 1 Product within the 130-day look-back period is excluded from Step Therapy.

Preferred product:

- Mupirocin ointment

Non-preferred product:

- Altabax
- Centany
- Centany AT
- Mupirocin cream (brand and generics)
- Xepi

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PREFERRED STEP THERAPY CRITERIA (FOR APPLICABLE REVIEWS)

1. If the patient has tried a preferred product, then authorization for a non-preferred product may be given.

Approval Duration: 365 days (1 year)

Step Therapy Exception Criteria

In certain situations, the patient is not required to trial preferred products. Approve for 1 year if the patient meets the following (A, B, or C):

A. The patient has an atypical diagnosis and/or unique patient characteristics which prevent use of all preferred products. If so, please list diagnosis and/or patient characteristics [documentation required]; **OR**
B. The patient has a contraindication to all preferred products. If so, please list the contraindications to each preferred product [documentation required]; **OR**
C. The patient is continuing therapy with the requested non-preferred product after being stable for at least 90 days [verification in prescription claims history required] or, if not available, [verification by prescribing physician required] AND meets ONE of the following:
    1. The patient has at least 130 days of prescription claims history on file and claims history supports that the patient has received the requested non-preferred product for 90 days within a 130-day look-back period AND there is no generic equivalent available for the requested nonpreferred product (i.e. AA-rated or AB-rated to the requested nonpreferred product); OR
    2. When 130 days of the patient's prescription claims history file is unavailable for verification, the prescriber must verify that the patient has been receiving the requested non-preferred product for 90 days AND that the patient has been receiving the requested non-preferred product via paid claims (i.e. the patient has NOT been receiving samples or coupons or other types of waivers in order to obtain access to the requested non-preferred product) AND there is no generic equivalent available for the requested nonpreferred product (i.e. AA-rated or AB-rated to the requested nonpreferred product).

Documentation Required: When documentation is required, the prescriber must provide written documentation supporting the trials of these other products, noted in the criteria as [documentation required]. Documentation should include chart notes, prescription claims records, and/or prescription receipts.

Approval Duration: All approvals for continuation of therapy are provided for 1 year unless noted otherwise below. In cases where the initial approval is authorized in months, 1 month is equal to 30 days.

Documentation Requirements:

The Company reserves the right to request additional documentation as part of its coverage determination process. The Company may deny reimbursement when it has determined that the drug provided or services performed were not medically necessary, investigational or experimental, not within the scope of benefits afforded to the member and/or a pattern of billing or other practice has been found to be either inappropriate or excessive. Additional documentation supporting medical necessity for the services provided must be made available upon request to the Company. Documentation requested may include patient records, test results and/or credentials of the provider ordering or performing a service. The Company also reserves the right to modify, revise, change, apply and interpret this policy at its sole discretion, and the exercise of this discretion shall be final and binding.

REFERENCES

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3. Facts and Comparisons Online. Wolters Kluwer Health, Inc.; 2018. Available at: http://online.factsandcomparisons.com/login.aspx?url=/index.aspx&qs=. Accessed on October 12, 2018. Search terms: mupirocin ointment.
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5. Xepi™ cream [prescribing information]. Fairfield, NJ: Medimetriks Pharmaceuticals, Inc.,; December 2017.
6. Stevens DL, Bisno AL, Chambers HF, et al. Practice guidelines for the diagnosis and management of skin and soft tissue infections, 2014 update by the Infectious Diseases Society of America. Clin Infect Dis. 2014;59(2):e10-e52.
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9. Centany AT® ointment [prescribing information]. Fairfield, NJ: Medimetriks Pharmaceuticals, Inc.; May 2017