

PA DEPARTMENT OF HUMAN SERVICES
MAAC BRIEFING DOCUMENT
ANTIPSORIATICS, TOPICAL

Proposed Effective Date: January 5, 2026

Revisions are noted with a ~~striketrough~~ for deletions and **bold and underline** for additions.

I. Requirements for Prior Authorization of Antipsoriatics, Topical

A. Revisions to Prescriptions That Require Prior Authorization

Prescriptions for Antipsoriatics, Topical that meet the following conditions must be prior authorized:

1. A non-preferred Antipsoriatic, Topical. See Preferred Drug List (PDL) for the list of preferred Antipsoriatics, Topical at: <https://papdl.com/preferred-drug-list>.
2. **An Antipsoriatics, Topical with a prescribed quantity that exceeds the quantity limit. The list of drugs that are subject to quantity limits, with accompanying quantity limits, is available at: <https://www.pa.gov/agencies/dhs/resources/pharmacy-services/quantity-limits-daily-dose-limits>.**
3. A topical aryl hydrocarbon receptor (AhR) agonist **(e.g., tapinarof)**.
4. A topical phosphodiesterase type 4 (PDE4) inhibitor **(e.g., roflumilast)**.

B. Revisions to Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for an Antipsoriatic, Topical, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. Is prescribed the Antipsoriatic, Topical for the treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication; **AND**
2. Is age-appropriate according to FDA-approved package labeling, national compendia, or peer-reviewed medical literature; **AND**
3. **Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; AND**
4. Does not have a contraindication to the prescribed drug; **AND**
5. For a topical AhR agonist **(e.g., tapinarof)**, **both** of the following:
 - a. **One of the following:**
 - i. **For treatment of atopic dermatitis, see the prior authorization guideline for**

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Immunomodulators, Dermatologics,

- ii. **For treatment of psoriasis, has a history of therapeutic failure of or a contraindication or an intolerance to both of the following:**
 - a) ~~Has a history of therapeutic failure of or a contraindication or an intolerance to A~~ four-week trial of a topical corticosteroid approved or medically accepted for the treatment of the beneficiary's diagnosis
 - b) ~~Has a history of therapeutic failure of or a contraindication or an intolerance to An~~ eight-week trial of a topical calcineurin inhibitor **a non-steroidal topical pharmacologic product** approved or medically accepted for the treatment of the beneficiary's diagnosis **(e.g., topical calcineurin inhibitor, topical retinoid, topical vitamin D analog),**
- iii. **For treatment of all other diagnoses, has a history of therapeutic failure of or a contraindication or an intolerance to first line therapy(ies) if applicable according to consensus treatment guidelines**
- b. **For a non-preferred topical AhR agonist, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred topical AhR agonists approved or medically accepted for the beneficiary's diagnosis;**

AND

- 6. For a topical PDE4 inhibitor **(e.g., roflumilast), both** of the following:
 - a. **One of the following:**
 - i. **For treatment of atopic dermatitis, see the prior authorization guideline for Immunomodulators, Dermatologics,**
 - ii. **For treatment of psoriasis, has a history of therapeutic failure of or a contraindication or an intolerance to topical calcipotriene,**
 - a) ~~Has a history of therapeutic failure of or a contraindication or an intolerance to A~~ four-week trial of a topical corticosteroid approved or medically accepted for the treatment of the beneficiary's diagnosis
 - b) ~~Has a history of therapeutic failure of or a contraindication or an intolerance to an~~ eight-week trial of a topical calcineurin inhibitor approved or medically accepted for the treatment of the beneficiary's diagnosis,
 - iii. **For treatment of seborrheic dermatitis, has a history of therapeutic failure of or a contraindication or an intolerance to at least one of the following:**
 - a) **A four-week trial of a topical antifungal approved or medically accepted for the treatment of the beneficiary's diagnosis,**

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- b) A four-week trial of a topical corticosteroid approved or medically accepted for the treatment of the beneficiary's diagnosis,
- c) A four-week trial of a topical calcineurin inhibitor approved or medically accepted for the treatment of the beneficiary's diagnosis,
- iv. For treatment of all other diagnoses, has a history of therapeutic failure of or a contraindication or an intolerance to first line therapy(ies) if applicable according to consensus treatment guidelines
- b. For a non-preferred topical PDE4 inhibitor, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred topical PDE4 inhibitors approved or medically accepted for the beneficiary's diagnosis;

AND

- 2. For all other non-preferred Antipsoriatics, Topical, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Antipsoriatics, Topical approved or medically accepted for the treatment of the beneficiary's diagnosis;

AND

- 3. If a prescription for an Antipsoriatics, Topical is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in the Quantity Limits Chapter.

NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

FOR RENEWALS OF PRIOR AUTHORIZATION FOR ANTIPSORIATICS, TOPICAL: The determination of medical necessity of a request for renewal of a prior authorization for an Antipsoriatics, Topical that was previously approved will take into account whether the beneficiary:

- 1. Has documentation of a positive clinical response to the prescribed drug; AND
- 2. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; AND
- 3. For a non-preferred topical AhR agonist, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred topical AhR agonists approved or medically accepted for the beneficiary's diagnosis; AND

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4. **For a non-preferred topical PDE4 inhibitor, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred topical PDE4 inhibitors approved or medically accepted for the beneficiary's diagnosis; AND**
5. **For all other non-preferred Antipsoriatics, Topical, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Antipsoriatics, Topical approved or medically accepted for the treatment of the beneficiary's diagnosis; AND**
6. **If a prescription for an Antipsoriatics, Topical is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in the Quantity Limits Chapter.**

NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

B. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for an Antipsoriatic, Topical. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.