# Policy: Topical Moisturizers

Reference Number: OR.CP.PMN.1014
Effective Date: 04.01.2024
Last Review Date: 02.25
Line of Business: Medicaid – Trillium Oregon Health Plan

Revision Log

**See Important Reminder at the end of this policy for important regulatory and legal information.**

**Goals**

- Limit use to funded conditions. Allow case-by-case review for members covered under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program.

**Covered Alternatives:**

- Current Trillium Preferred Drug List listed at:
  1. https://www.trilliumohp.com/providers/pharmacy.html

**Policy/Criteria**

*Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.*

It is the policy of Trillium Community Health Plan that requested medication is **medically necessary** when the following criteria are met:

**I. Initial Approval Criteria**

**A. All Indications** (must meet all):

1. One of the following conditions is met (a, b, or c):
   a. Member has severe skin disease as defined by the Prioritized List (see Appendix A);
   b. Member is eligible for EPSDT review and was born in or after the year 2004;
2. If request is for a non-preferred agent, member has failed treatment with at least two preferred drugs at maximally allowed dosing for ≥ 30 days; supported by one of the following (a, b, or c):
   a. Presence of claims in pharmacy claims history or documentation in chart notes;
   b. Documented contraindication(s) or clinically significant adverse effects to ALL PDL agents within the same therapeutic class or PDL drugs that are recognized as standards of care for the treatment of insomnia;
   c. Drug sample logs which include all of the following: medication name, dose/strength, lot number, expiration date, quantity dispensed, date sample was provided, and initials/title of the dispenser;

**Approval duration: Duration of request or 12 months (whichever is less)**

**II. Continued therapy**

**A. All Indications** (must meet all):

1. Member meets one of the following (a or b):

a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);

2. Member is responding positively to therapy;

**Approval duration: Duration of request or 12 months (whichever is less)**

## III. Diagnoses/Indications for which coverage is NOT authorized:

**A. Non-FDA approved indications**, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy: CP.PMN.53 for Medicaid or evidence of coverage documents.

## IV. Appendices/General Information

*Appendix A: Definition of Severe Skin Disease*

Severe disease is defined by the Prioritized List as:

- Having functional impairment as indicated by Dermatology Life Quality Index (DLQI) ≥ 11 or Children's Dermatology Life Quality Index (CDLQI) ≥ 13 (or severe score on other validated tool) AND one or more of the following:
  1. At lease 10% body surface area involved OR
  2. Hand, foot, face or mucous membrane involvement.

## V. References

1. Moisturizers, topical. Oregon Health Plan Current Drug Use Criteria. Available at: http://orpdl.org/drugs/index.php. Accessed January 17, 2025.
2. Micromedex® Healthcare Series [Internet database]. Greenwood Village, Colo: Thomson Healthcare. Updated periodically. Accessed January 17, 2025.

| Reviews, Revisions, and Approvals | Date | Plan Approval Date |
|---|---|---|
| Policy created | 12.28.23 | 02.20.24 |
| Added standard YSHCN language to I.A. for new 2025 OHP program coverage. | 10.16.24 | 11.19.24 |
| 1Q 2025 annual review: no significant changes; references reviewed and updated. | 01.17.25 | 02.11.25 |

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in

developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.



**Note:**
**For Medicaid members**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.