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5.90.024

Section:	Prescription Drugs	**Effective Date:**	October 1, 2024
Subsection:	Topical Products	**Original Policy Date:**	October 14, 2016
Subject:	Topical Anti-Inflammatories	**Page:**	1 of 5

Last Review Date: September 6, 2024

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 eczematoid 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 and Novacort may be considered **medically necessary** if the conditions indicated below are met.

Alcortin A and Novacort may be considered **investigational** 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

1. Moses, S. Pruritis. American Family Physician 2003; 68:1135-42.
2. Novacort [package Insert]. Chicago, IL: Novum Pharma LLC.; March 2018.
3. Alcortin A [package Insert]. Chicago, IL: Novum Pharma LLC.; March 2018.

Policy History

Date	Action
October 2016	Addition to PA
December 2016	Annual review
January 2017	Removal of Aloquin
September 2017	Annual editorial review and reference update Addition to Managed PA
September 2018	Annual review and reference update
February 2019	Addition of statement to Alcortin-A: *Prior authorization for the brand formulation applies only to formulary exceptions due to being a non-covered medication.
March 2019	Annual review
December 2019	Annual review. Moved Novacort to MFE with PA only
September 2020	Annual review
December 2021	Annual review
December 2022	Annual review. Changed policy number to 5.90.024
September 2023	Annual review
September 2024	Annual review

Keywords

This policy was approved by the FEP® Pharmacy and Medical Policy Committee on September 6, 2024 and is effective on October 1, 2024.