Pharmacy Drug Policy Checklist

POLICY NAME	Crotan (crotamiton)	POLICY #	2416P

Criteria

Coverage Criteria for Scabies

- ☐ **1.1** Documented diagnosis of scabies
- ☐ **1.2** Documented previous trial and failure, intolerance, or contraindication to topical permethrin AND oral ivermectin
  - Contraindications to oral ivermectin include pregnant or lactating women and children less than 15kg

Coverage Criteria for Pruritus/Urticaria

- ☐ **2.1** Documented diagnosis of pruritus/urticarial (itchy rash or hives)
- ☐ **2.2** Documented previous trial and failure, intolerance, or contraindication to topical steroids AND antihistamines (hydrocortisone, cetirizine, loratadine, fexofenadine, etc)