

Policy Name:	Crotan (crotamiton)	Policy#:	2416P
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Purpose of the Policy

The purpose of this policy is to define coverage criteria for Crotan (crotamiton).

Statement of the Policy

Health Alliance Medical Plans will approve the use of Crotan (crotamiton) if the following criteria are met.

Criteria

1. 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

2. 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)

3. Managed Dose Limit

- 3.1 All dermatological products have a Managed Dose Limit (MDL) in place allowing only the smallest package size of each product to process
- 3.2 Requests for larger package sizes will require documentation of medical necessity, including the following:
 - At least two previous paid claims for the product in the smallest package size within the previous month

4. Approval Period

- 4.1 6 months

CPT Codes

HCPCS Codes

References

- 1. Crotan (crotamiton) [prescribing information]. Charleston, SC: Marnell Pharmaceuticals LLC;

December 2021.

2. Johnstone P, Strong M. Scabies. BMJ Clin Evid. 2014;2014 Epub 2014 Dec 22.
3. Currie BJ, McCarthy JS. Permethrin and ivermectin for scabies. N Engl J Med. 2010;362(8):717.
4. Zuberbier T, Asero R, Bindslev-Jensen C, et al. EAACI/GA(2)LEN/EDF/WAO guideline: management of urticaria. Allergy. 2009;64(10):1427.
5. Grattan C, Powell S, Humphreys F, British Association of Dermatologists. Management and diagnostic guidelines for urticaria and angio-oedema. Br J Dermatol. 2001;144(4):708.

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DISCLAIMER

This Medical Policy has been developed as a guide for determining medical necessity. The process of medical necessity review also entails review of the most recent literature and physician review. Medical Policy is not intended to dictate to providers how to practice medicine. Providers are expected to exercise their medical judgment in providing the most appropriate care. Health Alliance encourages input from providers when developing and implementing medical policies. Benefit determinations are based on applicable contract language in the member's Policy/ Subscription Certificate/ Summary Plan Description. This Medical Policy does not guarantee coverage. There may be a delay between the revision of this policy and the posting on the web. Please contact the Health Alliance Customer Service Department at 1-800-851-3379 for verification of coverage.