Pharmacy Drug Policy Checklist

POLICY NAME	Hyftor (topical sirolimus)	POLICY #	3178P

Criteria

Coverage Criteria for Facial Angiofibroma

- ☐ **1.1** Documented diagnosis of facial angiofibroma associated with tuberous sclerosis (TSC)
- ☐ **1.2** Age 6 years or older
- ☐ **1.3** Prescribed by or in consultation with a dermatologist (skin doctor)

or more papules of angiofibroma (≥2 mm in diameter with redness) on the face

- ☐ **1.5** Patient has previously tried or is not a candidate for laser therapy or surgery