

POLICY NAME	Klisyri (tirbanibulin)	POLICY #	2826P
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Criteria

Coverage Criteria for Actinic Keratosis

- ☐ Documented diagnosis of actinic keratosis present on face and/or scalp
- ☐ Ordered by or in consultation with a dermatologist (skin doctor)
- ☐ Documented failure or contraindication to fluorouracil
- ☐ Documented failure or contraindication to cryotherapy (cold therapy to remove keratosis)
- ☐ Documented failure or contraindication to imiquimod cream
 - Applicable to be used in the presence of multiple, flat lesions

Exclusion Criteria – Any of the following prevents coverage

- ☐ Presence of atypical, hypertrophic (thickened, widened or raised), unresponsive, or rapidly changing actinic keratosis
- ☐ Open wounds or suspected skin cancers in proximity to the area where the ointment was to be applied