Pharmacy Drug Policy Checklist

POLICY NAME	Klisyri (tirbanibulin)	POLICY #	2826P

Criteria

Coverage Criteria for Actinic Keratosis

- ☐ **1.1** Documented diagnosis of actinic keratosis present on face and/or scalp
- ☐ **1.2** Ordered by or in consultation with a dermatologist (skin doctor)
- ☐ **1.3** Documented failure or contraindication to fluorouracil
- ☐ **1.4** Documented failure or contraindication to cryotherapy (cold therapy to remove keratosis)
- ☐ **1.5** 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

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