Clinical Policy: Luliconazole Cream (Luzu)

Description
Luliconazole cream (Luzu™) is an azole antifungal.

FDA Approved Indication(s)
Luzu is indicated for the topical treatment of interdigital tinea pedis, tinea cruris, and tinea corporis caused by the organisms *Trichophyton rubrum* and *Epidermophyton floccosum*.

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Luzu is medically necessary when the following criteria are met:

I. Initial Approval Criteria
A. Tinea Infections (must meet all):
   1. Diagnosis of tinea pedis, tinea cruris, or tinea corporis;
   2. Age ≥ 2 years;
   3. Failure of two formulary topical azole antifungal products (e.g., clotrimazole, ketoconazole, econazole), unless contraindicated or clinically significant adverse effects are experienced;
   4. Dose does not exceed one tube (60 g) per month.
   
   **Approval duration: 4 weeks**

B. Other diagnoses/indications
   1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy
A. Tinea Infections
   1. Re-authorization is not permitted. Members must meet the initial approval criteria.
   
   **Approval duration: Not applicable**
B. Other diagnoses/indications (must meet 1 or 2):
   1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
      Approval duration: Duration of request or 6 months (whichever is less); or
   2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:
   A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information
   Appendix A: Abbreviation/Acronym Key
   FDA: Food and Drug Administration

   Appendix B: Therapeutic Alternatives
   This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>clotrimazole cream (Desenex®, Lotrim® AF, Pro-Ex® Antifungal, Shopko® Athletes Foot), solution, ointment (Alevazo®)</td>
<td>Apply to affected area BID</td>
<td>Varies</td>
</tr>
<tr>
<td>econazole cream, foam (Ecoza®)</td>
<td>Apply to affected area QD</td>
<td>Varies</td>
</tr>
<tr>
<td>ketoconazole cream</td>
<td>Apply to affected and immediate surrounding area QD</td>
<td>Varies</td>
</tr>
<tr>
<td>miconazole (Lotromin AF, Cruex®, Desenex®, Micro Guard®, Zeasorb-AF®)</td>
<td>Apply to affected area BID</td>
<td>Varies</td>
</tr>
<tr>
<td>oxiconazole cream, lotion (Oxistat®)</td>
<td>Apply to affected area QD – BID</td>
<td>Varies</td>
</tr>
<tr>
<td>Ertaczo® (sertaconazole cream)</td>
<td>Tinea pedis: apply to affected area BID</td>
<td>Varies</td>
</tr>
<tr>
<td>Exelderm® (sulconazole cream, solution)</td>
<td>Tinea corporis/tinea cruris: apply to affected and surrounding area QD – BID Tinea pedis (cream): apply to affected area BID</td>
<td>Varies</td>
</tr>
</tbody>
</table>

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.
Appendix C: Contraindications/Boxed Warnings
None reported

V. Dosage and Administration

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tinea pedis</td>
<td>Apply to affected and immediate surrounding area(s) QD for 2 weeks</td>
<td>Varies</td>
</tr>
<tr>
<td>Tinea cruris, tinea corporis</td>
<td>Apply to affected skin and immediate surrounding area(s) QD for 1 week</td>
<td>Varies</td>
</tr>
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</table>

VI. Product Availability
Cream (1%): 60 g

VII. References

Reviews, Revisions, and Approvals

<table>
<thead>
<tr>
<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy created</td>
<td>08.28.18</td>
<td>11.18</td>
</tr>
<tr>
<td>1Q 2019 annual review: no significant changes; references reviewed and updated.</td>
<td>10.30.18</td>
<td>02.19</td>
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<tr>
<td>1Q 2020 annual review: no significant changes; references reviewed and updated.</td>
<td>10.29.19</td>
<td>02.20</td>
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Important Reminder
This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and
limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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