blue of california

pimecrolimus, cream (ELIDEL)

Diagnosis Considered for Coverage:

- Atopic dermatitis or eczema
- Psoriasis on face or intertriginous area
- Vitiligo where the affected area is on the face or groin
- Perioral dermatitis

Coverage Criteria:

1. **For treatment of atopic dermatitis (eczema):**
   - Quantity does not exceed 1 tube per month, **and**
   - One of the following:
     - Affected area(s) is on the face or groin, **or**
     - Inadequate response, intolerable side effect, or contraindication to ONE topical corticosteroid in the medium, high, or very high potency group.

2. **For diagnosis of psoriasis:**
   - Affected area(s) is on the face or intertriginous areas *(see Additional Information section),* **and**
   - Quantity does not exceed 1 tube per month.

3. **For diagnosis of vitiligo:**
   - Affected area(s) is on the face or groin, **and**
   - Quantity does not exceed 1 tube per month.

4. **For diagnosis of perioral dermatitis:**
   - Quantity does not exceed 1 tube per month.

Coverage Duration: one year

Effective Date: 6/01/2022