Pennsylvania
Department of Human Services

Medical Assistance BULLETIN

ISSUE DATE	EFFECTIVE DATE	NUMBER
November 14, 2025	January 5, 2026	*See below

SUBJECT

Prior Authorization of Immunomodulators, Dermatologics (formerly Immunomodulators, Atopic Dermatitis) – Pharmacy Services

BY

Sally Kozak
Deputy Secretary
Office of Medical Assistance Programs

IMPORTANT REMINDER: All providers must revalidate the Medical Assistance (MA) enrollment of each service location every 5 years. Providers should log into PROMISe to check the revalidation dates of each service location and submit revalidation applications at least 60 days prior to the revalidation dates. Enrollment (revalidation) applications may be found at: https://www.pa.gov/en/agencies/dhs/resources/for-providers/provider-enrollment-information/provider-enrollment-documents.html.

PURPOSE:

The purpose of this bulletin is to issue updated handbook pages that include the requirements for prior authorization and the type of information needed to evaluate the medical necessity of prescriptions for Immunomodulators, Dermatologics submitted for prior authorization.

SCOPE:

This bulletin applies to all licensed pharmacies and prescribers enrolled in the Medical Assistance (MA) Program. The guidelines to determine the medical necessity of Immunomodulators, Dermatologics will be utilized in the fee-for-service and managed care delivery systems. Providers rendering services to MA beneficiaries in the managed care delivery system should address any questions related to the prior authorization of Immunomodulators, Dermatologics to the appropriate managed care organization.

BACKGROUND:

The Department of Human Services' (Department) Pharmacy and Therapeutics (P&T) Committee reviews published peer-reviewed medical literature and recommends the following:

*01-26-23	09-26-23	27-26-23	33-26-23
02-26-23	11-26-23	30-26-23	
03-26-23	14-26-23	31-26-23	
08-26-23	24-26-23	32-26-23	

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

Fee-for-Service Provider Service Center: 1-800-537-8862

Visit the Office of Medical Assistance Programs website at:
https://www.pa.gov/en/agencies/dhs/departments-offices/omap-info.html

- Preferred or non-preferred status for new drugs and products in therapeutic classes already included on the Statewide Preferred Drug List (PDL).
- Changes to the statuses of drugs and products on the Statewide PDL from preferred to non-preferred and non-preferred to preferred.
- Therapeutic classes of drugs and products to be added to or deleted from the Statewide PDL.
- New quantity limits.
- New guidelines or revisions to existing guidelines to evaluate the medical necessity of prescriptions submitted for prior authorization.

DISCUSSION:

During the September 24, 2025, meeting, the P&T Committee recommended the following revisions to the guidelines to determine medical necessity of Immunomodulators, Dermatologics:

- Revision of the title of the Immunomodulators, Atopic Dermatitis Statewide PDL therapeutic class to Immunomodulators, Dermatologics.
- Addition of a requirement for prior authorization of and corresponding medical necessity guidelines for topical aryl hydrocarbon receptor agonists (e.g., tapinarof).
- Revision of the guidelines for topical phosphodiesterase type 4 inhibitors, topical Janus kinase inhibitors, and targeted systemic Immunomodulators, Dermatologics to address expanded indications other than atopic dermatitis approved by the U.S. Food and Drug Administration.
- Revision of the guidelines for targeted systemic Immunomodulators, Dermatologics to clarify the guideline related to the treatment of atopic dermatitis.
- Revision of the guideline for non-preferred targeted systemic Immunomodulators, Dermatologics.

The revisions to the guidelines to determine medical necessity of prescriptions for Immunomodulators, Dermatologics submitted for prior authorization, as recommended by the P&T Committee, were subject to public review and comment and subsequently approved for implementation by the Department.

PROCEDURE:

The procedures for prescribers to request prior authorization of Immunomodulators, Dermatologics are located in SECTION I of the Prior Authorization of Pharmaceutical Services Handbook. The Department will take into account the elements specified in the clinical review guidelines (which are included in the provider handbook pages in the SECTION II chapter related to Immunomodulators, Dermatologics) when reviewing the prior authorization request to determine medical necessity.

As set forth in 55 Pa. Code § 1101.67(a), the procedures described in the handbook pages must be followed to ensure appropriate and timely processing of prior authorization requests for drugs and products that require prior authorization.

ATTACHMENTS:

Prior Authorization of Pharmaceutical Services Handbook - Updated pages

RESOURCES:

Prior Authorization of Pharmaceutical Services Handbook – SECTION I
Pharmacy Prior Authorization General Requirements
https://www.pa.gov/en/agencies/dhs/resources/pharmacy-services/pharmacy-prior-authorization-general-requirements.html

Prior Authorization of Pharmaceutical Services Handbook – SECTION II
Pharmacy Prior Authorization Guidelines
https://www.pa.gov/en/agencies/dhs/resources/pharmacy-services/clinical-guidelines.html

I. Requirements for Prior Authorization of Immunomodulators, Dermatologics

A. Prescriptions That Require Prior Authorization

Prescriptions for Immunomodulators, Dermatologics that meet the following conditions must be prior authorized:

1. A non-preferred Immunomodulators, Dermatologic. See the Preferred Drug List (PDL) for the list of preferred Immunomodulators, Dermatologics at: https://papdl.com/preferred-drug-list.

2. An Immunomodulators, Dermatologic with a prescribed quantity that exceeds the quantity limit. The list of drugs that are subject to quantity limits, with accompanying quantity limits, is available at: https://www.pa.gov/en/agencies/dhs/resources/pharmacy-services/quantity-limits-daily-dose-limits.html.

3. A topical Janus kinase (JAK) inhibitor (e.g., delgocitinib, ruxolitinib).

4. A topical phosphodiesterase type 4 (PDE4) inhibitor (e.g., crisaborole, roflumilast).

5. A topical aryl hydrocarbon receptor (AhR) agonist (e.g., tapinarof).

6. A targeted systemic Immunomodulators, Dermatologic (e.g., abrocitinib, nemolizumab, tralokinumab, upadacitinib).

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for an Immunomodulators, Dermatologic, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. For Dupixent (dupilumab), see the prior authorization guideline related to Dupixent (dupilumab); **OR**

2. Is prescribed the Immunomodulators Dermatologic for the treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling or a medically accepted indication; **AND**

3. Is age-appropriate according to FDA-approved package labeling, national compendia, or peer-reviewed medical literature; **AND**

4. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

5. Does not have a contraindication to the requested drug; **AND**

6. For a non-preferred topical calcineurin inhibitor, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred topical calcineurin inhibitors; **AND**

7. For a topical PDE4 inhibitor (e.g., crisaborole, roflumilast), **both** of the following:

    a. **One** of the following:

        i. For treatment of psoriasis or seborrheic dermatitis, see the prior authorization guideline for Antipsoriatics, Topical,

        ii. For treatment of atopic dermatitis, has a history of therapeutic failure of or a contraindication or an intolerance to **both** of the following:

            a) A four-week trial of a topical corticosteroid approved or medically accepted for the treatment of the beneficiary's diagnosis
            b) An eight-week trial of a topical calcineurin inhibitor approved or medically accepted for the treatment of the beneficiary's diagnosis,

        iii. For treatment of all other diagnoses, has a history of therapeutic failure of or a contraindication or an intolerance to first line therapy(ies) if applicable according to consensus treatment guidelines

    b. For a non-preferred topical PDE4 inhibitor, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred topical PDE4 inhibitors approved or medically accepted for the beneficiary's diagnosis;

    AND

8. For a topical JAK inhibitor (e.g., ruxolitinib), **both** of the following:

    a. **One** of the following:

        i. For treatment of atopic dermatitis, has a history of therapeutic failure of or a contraindication or an intolerance to **both** of the following:

            a) A four-week trial of a topical corticosteroid approved or medically accepted for the treatment of the beneficiary's diagnosis
            b) An eight-week trial of a topical calcineurin inhibitor approved or medically accepted for the treatment of the beneficiary's diagnosis,

        ii. For treatment of chronic hand eczema, has a history of therapeutic failure of or a contraindication or an intolerance to **both** of the following:

            a) A four-week trial of a topical corticosteroid approved or medically accepted for the treatment of the beneficiary's diagnosis

b) An eight-week trial of a topical calcineurin inhibitor approved or medically accepted for the treatment of the beneficiary's diagnosis,

iii. For treatment of vitiligo, has a history of therapeutic failure of or a contraindication or an intolerance to **both** of the following:

a) A four-week trial of a topical corticosteroid approved or medically accepted for the treatment of the beneficiary's diagnosis
b) An eight-week trial of a topical calcineurin inhibitor approved or medically accepted for the treatment of the beneficiary's diagnosis,

iv. For treatment of all other diagnoses, has a history of therapeutic failure of or a contraindication or an intolerance to first line therapy(ies) if applicable according to consensus treatment guidelines

b. For a non-preferred topical JAK inhibitor, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred topical JAK inhibitors approved or medically accepted for the beneficiary's diagnosis;

AND

9. For a topical AhR agonist (e.g., tapinarof), **both** of the following:

a. **One** of the following:

i. For treatment of psoriasis, see the prior authorization guideline for Antipsoriatics, Topical,

ii. For treatment of atopic dermatitis, has a history of therapeutic failure of or a contraindication or an intolerance to **both** of the following:

a) A four-week trial of a topical corticosteroid approved or medically accepted for the treatment of the beneficiary's diagnosis
b) An eight-week trial of a topical calcineurin inhibitor approved or medically accepted for the treatment of the beneficiary's diagnosis,

iii. For treatment of all other diagnoses, has a history of therapeutic failure of or a contraindication or an intolerance to first line therapy(ies) if applicable according to consensus treatment guidelines

b. For a non-preferred topical AhR agonist, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred topical AhR agonists approved or medically accepted for the beneficiary's diagnosis;

AND

10. For all other non-preferred topical Immunomodulators, Dermatologics, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred topical Immunomodulators, Dermatologics approved or medically accepted for the beneficiary's diagnosis; **AND**

11. For a targeted systemic Immunomodulators, Dermatologic, **all** of the following:

    a. Is prescribed the targeted systemic Immunomodulators, Dermatologic by or in consultation with an appropriate specialist (e.g., dermatologist),

    b. If currently using a different targeted systemic Immunomodulators, Dermatologic, will discontinue the other targeted systemic Immunomodulators, Dermatologic prior to starting the requested targeted systemic Immunomodulators, Dermatologic,

    c. For treatment of chronic atopic dermatitis, **both** of the following:

        i. Has atopic dermatitis associated with at least **one** of the following:

            a) A body surface area of 10% or greater that is affected,
            b) Involvement of critical areas (e.g., face, feet, genitals, hands, intertriginous areas, scalp),
            c) Significant disability or impairment of physical, mental, or psychosocial functioning

        ii. Has a history of therapeutic failure of or a contraindication or an intolerance to **both** of the following:

            a) A four-week trial of a topical corticosteroid approved or medically accepted for the treatment of the beneficiary's diagnosis
            b) An eight-week trial of a topical calcineurin inhibitor approved or medically accepted for the treatment of the beneficiary's diagnosis,

    d. For treatment of prurigo nodularis, **both** of the following:

        i. Has a history of pruritis lasting at least six weeks

        ii. Has prurigo nodularis associated with at least **one** of the following:

            a) Greater than or equal to 20 nodular lesions
            b) Significant disability or impairment of physical, mental, or psychosocial functioning,

    e. For treatment of all other diagnoses, has a history of therapeutic failure of or a contraindication or an intolerance to first-line therapy(ies) if applicable according to current consensus treatment guidelines,

f. For an oral JAK inhibitor, **one** of the following:

   i. Has a history of therapeutic failure of at least one biologic if recommended for the beneficiary's diagnosis in the FDA-approved package labeling for the requested oral JAK inhibitor,
   ii. Has a contraindication or an intolerance to biologics if recommended for the beneficiary's diagnosis in the FDA-approved package labeling for the requested oral JAK inhibitor,
   iii. Has a current history (within the past 90 days) of being prescribed an oral JAK inhibitor,

g. For a non-preferred targeted systemic Immunomodulators, Dermatologic, **one** of the following:

   i. Has a history of therapeutic failure of or a contraindication or an intolerance to the preferred targeted systemic Immunomodulators, Dermatologics approved or medically accepted for the beneficiary's diagnosis
   ii. Has a current history (within the past 90 days) of being prescribed the same targeted systemic Immunomodulators, Dermatologic (does not apply to non-preferred targeted systemic Immunomodulators, Dermatologics when a therapeutically equivalent brand/generic or corresponding biosimilar/brand biologic/unbranded biologic is preferred);

AND

12. If a prescription for an Immunomodulators, Dermatologic is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in the Quantity Limits Chapter.

    NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

FOR RENEWALS OF PRIOR AUTHORIZATION FOR AN IMMUNOMODULATORS, DERMATOLOGIC: The determination of medical necessity of a request for renewal of a prior authorization for an Immunomodulators, Dermatologic that was previously approved will take into account whether the beneficiary:

1. Has documented evidence of improvement of disease severity; **AND**

2. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

3. Does not have a contraindication to the requested drug; **AND**

4. For a non-preferred topical calcineurin inhibitor, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred topical calcineurin inhibitors; **AND**

5. For a non-preferred topical PDE4 inhibitor, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred topical PDE4 inhibitors approved or medically accepted for the beneficiary's diagnosis; **AND**

6. For a non-preferred topical JAK inhibitor, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred topical JAK inhibitors approved or medically accepted for the beneficiary's diagnosis; **AND**

7. For a non-preferred topical AhR agonist, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred topical AhR agonists approved or medically accepted for the beneficiary's diagnosis; **AND**

8. For all other non-preferred topical Immunomodulators, Dermatologics, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred topical Immunomodulators, Dermatologics approved or medically accepted for the beneficiary's diagnosis; **AND**

9. For a targeted systemic Immunomodulator, Dermatologics, **both** of the following:

    a. Is prescribed the targeted systemic Immunomodulators, Dermatologic by or in consultation with an appropriate specialist (e.g., dermatologist)
    b. For a non-preferred targeted systemic Immunomodulators, Dermatologic with a therapeutically equivalent brand/generic or corresponding biosimilar/brand biologic/unbranded biologic that is preferred on the PDL, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred therapeutically equivalent brand/generic or corresponding biosimilar/brand biologic/unbranded biologic that would not be expected to occur with the requested drug;

    AND

10. If a prescription for an Immunomodulators, Dermatologic is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in the Quantity Limits Chapter.

    NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for an Immunomodulators, Dermatologic. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

D. References

1. Adbry [package insert]. Madison, NJ: LEO Pharma Inc.; June 2024.
2. Cibinqo [package insert]. New York, NY: Pfizer Labs; December 2023.
3. Eucrisa [package insert]. New York, NY: Pfizer Labs; April 2023.
4. Nemluvio [package insert]. Dallas, TX: Galderma Laboratories, L.P. June 2025.
5. Opzelura [package insert]. Wilmington, DE: Incyte Corporation; January 2023.
6. Rinvoq [package insert]. North Chicago, IL: AbbVie Inc.; April 2025.
7. Vtama [package insert]. Long Beach, CA: Dermavant Sciences Inc. December 2024.
8. Wollenberg A, Christen-Zäch S, Taieb A, et al. ETFAD/EADV Eczema task force 2020 position paper on diagnosis and treatment of atopic dermatitis in adults and children. J Eur Acad Dermatol Venereol. 2020;34(12):2717-2744.
9. Drucker AM, Ellis AG, Bohdanowicz M, et al. Systemic immunomodulatory treatment for patients with atopic dermatitis – a systemic review and network meta-analysis. JAMA Dermatol. 2020;156(6):659-667.
10. Siegels D, Heratizadeh A, Abraham S, et al. Systemic treatments in the management of atopic dermatitis: A systematic review and meta-analysis. Allergy. 2021;76(4):1053-1076.
11. Sawangjit R, Dilokthornsakul P, Lloyd-Lavery A, Lai NM, Dellavalle R, Chaiyakunapruk N. Systemic treatments for eczema: A network meta-analysis. Cochrane Database Syst Rev. 2020;9:CD013206. Published September 14, 2020.
12. Atlas SJ, Brouwer E, Fox G, et al. JAK inhibitors and monoclonal antibodies for the treatment of atopic dermatitis: Effectiveness and value; evidence report. Institute for Clinical and Economic Review, July 9, 2021. Accessed July 13, 2021.
13. Howe W, Paller AS, Butala S. Treatment of atopic dermatitis (eczema). In: UpToDate [internet database]. Dellavalle RP, Levy ML, Fowler J, Corona R, eds. Waltham, MA: UpToDate. Updated July 25, 2023. Accessed August 1, 2023.
14. Lio PA. Management of severe atopic dermatitis (eczema) in children. In: UpToDate [internet database]. Dellavalle RP, Levy ML, Fowler J, Corona R, eds. Waltham, MA: UpToDate. Updated June 28, 2022. Accessed August 1, 2023.
15. Eleftheriadou V, Atkar R, Batchelor J, et al. British Association of Dermatologists guidelines for the management of people with vitiligo 2021. Br J Dermatol. 2022;186(1):18-29.
16. Grimes PE. Vitiligo: Management and prognosis. In: UpToDate [internet database]. Tsao H, Alexis AF, Corona R, eds. Waltham, MA: UpToDate Inc. Updated April 26, 2023. Accessed August 2, 2023.
17. Sidbury R, Alikhan A, Bercovitch L, et al. Guidelines of care for the management of atopic dermatitis in adults with topical therapies. J Am Acad Dermatol. 2023;89(1):e1-e20.