

## **Clinical Policy: Halcinonide (Halog)**

Reference Number: HIM.PA.20

Effective Date: 08.28.18

Last Review Date: 11.19

Line of Business: HIM

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### **Description**

Halcinonide (Halog<sup>®</sup>) is a high potency topical corticosteroid with anti-inflammatory, antipruritic and vasoconstrictive actions.

### **FDA Approved Indication(s)**

Halog is indicated for the relief of the inflammatory and pruritic manifestations of corticosteroid responsive dermatoses.

### **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<sup>®</sup> that Halog is **medically necessary** when the following criteria are met:

## **I. Initial Approval Criteria**

### **A. Dermatologic Inflammation and Pruritus (must meet all):**

1. Diagnosis of dermatologic inflammation or pruritus;
2. Failure of two formulary high potency topical corticosteroids in the previous 6 months, unless contraindicated or clinically significant adverse effects are experienced (*see Appendix B for examples*);
3. Dose does not exceed one 60 gm tube per month.

**Approval duration: 12 months**

### **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): HIM.PHAR.21 for health insurance marketplace.

## **II. Continued Therapy**

### **A. Dermatologic Inflammation and Pruritus (must meet all):**

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed one 60 gm tube per month.

**Approval duration: 12 months**

**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 12 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): HIM.PHAR.21 for health insurance marketplace.

**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 – HIM.PHAR.21 for health insurance marketplace 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.*

<b>Drug Name</b>	<b>Dosing Regimen</b>	<b>Dose Limit/ Maximum Dose</b>
augmented betamethasone 0.05% gel, cream, ointment, lotion (Diprolene <sup>®</sup> )	Apply topically to the affected area(s) BID	Should not be used for longer than 2 consecutive weeks
clobetasol propionate 0.05% cream, ointment, gel, solution (Temovate <sup>®</sup> )	Apply topically to the affected area(s) BID	Should not be used for longer than 2 consecutive weeks
diflorasone diacetate 0.05% ointment, cream (Apexicon <sup>®</sup> , Psorcon <sup>®</sup> )	Apply topically to the affected area(s) BID	Should not be used for longer than 2 consecutive weeks
halobetasol propionate 0.05% cream, ointment (Ultravate <sup>®</sup> )	Apply topically to the affected area(s) BID	Should not be used for longer than 2 consecutive weeks
fluocinonide acetone 0.05% cream, ointment,	Apply topically to the affected area(s) BID	Should not be used for longer than 2 consecutive weeks

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
gel, solution (Lidex <sup>®</sup> )		
desoximetasone 0.25% cream, ointment (Topicort <sup>®</sup> )	Apply topically to the affected area(s) BID	Should not be used for longer than 2 consecutive weeks
desoximetasone 0.05% cream, gel (Topicort <sup>®</sup> )	Apply topically to the affected area(s) BID	Should not be used for longer than 2 consecutive weeks
mometasone 0.1% ointment (Elocon <sup>®</sup> )	Apply topically to the affected area(s) BID	Should not be used for longer than 2 consecutive weeks

*Therapeutic alternatives are listed as Brand name<sup>®</sup> (generic) when the drug is available by brand name only and generic (Brand name<sup>®</sup>) when the drug is available by both brand and generic.*

*Appendix C: Contraindications/Boxed Warnings*

- Contraindication(s): history of hypersensitivity to any of the components of the preparation
- Boxed warning(s): none reported

**V. Dosage and Administration**

Indication	Dosing Regimen	Maximum Dose
Dermatologic inflammation and pruritus	Apply to the affected area BID to TID	3 applications/day

**VI. Product Availability**

- Cream (0.1%): 30 g, 60 g, 216
- Ointment (0.1%): 60 g

**VII. References**

1. Halog Cream Prescribing Information. San Antonio, TX: Sun Pharmaceutical Industries, Inc.; January 2019. Available at: <https://dailymed.nlm.nih.gov/dailymed/>. Accessed August 13, 2019.
2. Halog Ointment Prescribing Information. Princeton, NJ: Westwood-Squibb Pharmaceuticals, Inc. April 2003. Available at: [https://www.accessdata.fda.gov/drugsatfda\\_docs/label/2004/17824s024lbl.pdf](https://www.accessdata.fda.gov/drugsatfda_docs/label/2004/17824s024lbl.pdf). Accessed August 13, 2019.
3. Micromedex<sup>®</sup> Healthcare Series [Internet database]. Greenwood Village, Colo: Thomson Healthcare. Updated periodically. Accessed August 13, 2019.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	08.21.18	10.18
4Q 2019 annual review: no significant changes; references reviewed and updated.	08.13.19	11.19

**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 Health Insurance Marketplace members**, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the non-formulary policy; HIM.PA.103.

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