

CRITERIA FOR PRIOR AUTHORIZATION

Sernivo® (betamethasone dipropionate spray)

PROVIDER GROUP Pharmacy

MANUAL GUIDELINES The following drug requires prior authorization:
Betamethasone Dipropionate Spray (Sernivo)

CRITERIA FOR INITIAL PRIOR AUTHORIZATION FOR BETAMETHASONE DIPROPIONATE SPRAY: (must meet all of the following)

- Patient must have a diagnosis of mild to moderate plaque psoriasis
- Patient must be 18 years of age or older
- Must be prescribed by or in consultation with a Dermatologist
- Patient must have a trial of a mid-potency topical corticosteroid AND a high-potency topical corticosteroid

LENGTH OF APPROVAL: 4 weeks total per year

Notes:

- Administration Instructions: Do not use for longer than 4 consecutive weeks. Discontinue treatment when control is achieved. Do not use if atrophy is present at the treatment site. Avoid use on the face, scalp, axilla, groin, or other intertriginous areas.
- Mid-potency topical corticosteroids: fluocinolone 0.03% and higher, fluocinonide, fluticasone topical, hydrocortisone topical, mometasone topical, triamcinolone topical, flurandrenolide, prednicarbate)
- High-potency topical corticosteroids: betamethasone, clobetasol, desoximetasone, diflorasone, fluocinonide 0.1%, halcinonide, halobetasol, mometasone

DRUG UTILIZATION REVIEW COMMITTEE CHAIR

PHARMACY PROGRAM MANAGER
DIVISION OF HEALTH CARE FINANCE
KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

DATE

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