MagellanRx MANAGEMENT

New Hampshire Medicaid Fee-for-Service Program

Convenience Kits (Rx) Criteria

Approval Date: January 14, 2022

Medications

Brand Name	Generic Name	Strengths
Qutenza®	Capsaicin/Skin Cleanser	8%
Ciclodan®	Ciclopirox/Skin Cleanser No. 28	0.77%
Loprox®	Ciclopirox/Skin Cleanser No. 40	0.77%
Trilociclo™	Ciclopirox/Triamcinolone acetate	8%/0.1%
Ciclodan®	Ciclopirox/Urea/Camphor/Menthol/ Eucalyptus	8%
ciclopirox	Ciclopirox/Urea/Camphor/Menthol/ Eucalyptus	8%
Clindacin® ETZ	Clindamycin phosphate/Skin Cleanser No. 19	1%
Clindacin® PAC	Clindamycin phosphate/Skin Cleanser No. 19	1%
Neuac®	Clindamycin/Benzoyl/Emollient No. 94	1.2(1)%/5%
Clobetex™	Clobetasol/Desloratadine	0.05%/5 mg
Tovet®	Clobetasol/Emollient No. 65	0.05%
Clodan®	Clobetasol/Skin Cleanser No. 28	0.05%
Cyclopak™	Cyclobenzaprine/Lidocaine/Prilocaine/Glycerin	5mg/2.5%
Clofenax™	Diclofenac/Kinesiology Tape	1.5%
Diclotrex™	Diclofenac/Menthol/Camphor	1.5%/10%
Morgidox®	Doxycycline/Skin Cleanser No. 19	50 mg, 100 mg
Synalar®	Fluocinolone/Emollient No. 65	0.025%
Synalar® TS	Fluocinolone/Skin Cleanser No. 28	0.1%
Beser™	Fluticasone/Skin Cleanser No. 25	0.05%
aqua glycolic HC	Hydrocortisone/Skin Cleanser No. 25	2%
Ibupak™	Ibuprofen/Glycerin	600 mg
lidocaine-hydrocortisone	Lidocaine/Hydrocortisone AC	2%/2%
Prilo Patch II™	Lidocaine/Prilocaine	5%/2.5%/2.5%

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Rosadan®	Metronidazole/Skin Cleanser No. 23	0.75%
Neo-Synalar®	Neomycin/Fluocinolone/Emollient No. 65	0.5%/0.025%
Sumaxin CP®	Sulfacetamide/Sulfur/Skin Cleanser No. 23	10%/4%
Sumadan®	Sulfacetamide/Sulfur/Skin Cleanser No. 23	9%/4.5%
Sumadan XLT®	Sulfacetamide Sodium/Sulfur/Avobenzone/Octinoxate/ Octisalate	9%/4.5%

Criteria for Approval

1. Kit is being prescribed for the FDA (Food and Drug Administration)-approved indication for all active ingredients; **AND**
2. The patient has had an adequate trial of a product with the active ingredient(s)**; OR**
3. The active ingredient(s) is/are on drug shortage; **AND**
4. Non-preferred drugs on the Preferred Drug List (PDL) require additional prior authorization (PA).

Criteria for Denial

1. Failure to meet criteria for approval.

Approval period: 12 months

Criteria for Renewal

1. Patient must continue to meet above criteria.

References

Available upon request.

Revision History

Reviewed by	Reason for Review	Date Approved
DUR Board	New	12/02/2021
Commissioner Designee	New	01/14/2022