QUANTITY LIMIT PRIOR AUTHORIZATION CRITERIA

BRAND NAME
(generic)

EXTINA
(ketoconazole)

Status: CVS Caremark Criteria
Type: Quantity Limit; Post Limit Prior Authorization

POLICY

FDA-APPROVED INDICATIONS
Extina is indicated for the topical treatment of seborrheic dermatitis in immunocompetent adults and children 12 years of age and older.

INITIAL QUANTITY LIMIT*

LIMIT CRITERIA

<table>
<thead>
<tr>
<th>Drug</th>
<th>4 Weeks and 12 Weeks Limit*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extina (ketoconazole 2% topical foam)</td>
<td>100 grams / 21 days</td>
</tr>
</tbody>
</table>

*The duration of 21 days is used for a 28-day fill period to allow time for refill processing.

This drug is for short-term acute use; therefore, the mail limit will be the same as the retail limit. The intent is for prescriptions of the requested drug to be filled 4 weeks at a time; there should be no 12 week supplies filled.

**If the patient is requesting more than the initial quantity limit, the claim will reject with a message indicating that a prior authorization is required. The prior authorization criteria would then be applied to requests submitted for evaluation to the PA unit.

COVERAGE CRITERIA
The requested drug will be covered with prior authorization when the following criteria are met:

- The requested drug is being prescribed for the treatment of seborrheic dermatitis AND
- The requested drug is being prescribed to treat a body surface area that requires more than 100 grams in a 4 week period

Quantity Limits apply.

<table>
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*The duration of 21 days is used for a 28-day fill period and 63 days is used for an 84-day fill period to allow time for refill processing.
REFERENCES