

Clinical Policy Title:	tirbanibulin
Policy Number:	RxA.667
Drug(s) Applied:	Klisyri®
Original Policy Date:	03/09/2021
Last Review Date:	12/11/2025
Line of Business Policy Applies to:	All lines of business (except Medicare)

Criteria

I. Initial Approval Criteria

A. Actinic Keratosis (AK) (must meet all):

1. Diagnosis of actinic keratosis (AK);
2. Prescribed for use on face or scalp only;
3. Trial and failure of at least two of the following preferred topical agents used to treat AK, unless contraindications or clinically significant adverse reactions were experienced;
 - a. Fluorouracil topical product;
 - b. Imiquimod topical product.

Approval Duration

All Lines of Business (except Medicare): 5 days

II. Continued Therapy Approval

A. Actinic Keratosis (AK) (must meet all):

1. Member is currently receiving or has been treated with this medication within the past 120 days, excluding manufacturer samples;
2. The medication is prescribed for treating new lesions.

Approval Duration

All Lines of Business (except Medicare): 5 days

References

Not Applicable

Review/Revision History	Review/Revision Date	P&T Approval Date
Policy established.	03/09/2021	03/09/2021
Policy was reviewed: 1. Continued Therapy Approval Criteria II.A.1 was rephrased to "Member is currently receiving medication that has been authorized by RxAdvance...".	12/8/2021	01/17/2022
Policy was reviewed.	10/20/2022	01/17/2023
Policy was reviewed.	10/19/2023	10/19/2023

This clinical policy has been developed to authorize, modify, or determine coverage for individuals with similar conditions. Specific care and treatment may vary depending on individual need and benefits covered by the plan. This policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. This document may contain prescription brand name drugs that are trademarks of pharmaceutical manufacturers that are not affiliated with RxAdvance.

Policy was reviewed: 1. Removed age restrictions. 2. Removed prescriber restrictions. 3. Removed dose restrictions. 4. Updated Continued therapy approval with the new verbiage containing 120 days lookback period. 5. Removed reauthorization requirement for positive response to therapy. 6. Updated approval duration verbiage.	08/28/2024	09/13/2024
Policy was reviewed.	12/05/2024	N/A
Policy reviewed.	12/11/2025	12/11/2025