Altabax (Retapamulin)

Clinical Criteria Information Included in this Document

- **Drugs requiring prior authorization**: the list of drugs requiring prior authorization for this clinical criteria
- **Prior authorization criteria logic**: a description of how the prior authorization request will be evaluated against the clinical criteria rules
- **Logic diagram**: a visual depiction of the clinical criteria logic
- **Supporting tables**: a collection of information associated with the steps within the criteria (diagnosis codes, procedure codes, and therapy codes); provided when applicable
- **References**: clinical publications and sources relevant to this clinical criteria

**Note**: Click the hyperlink to navigate directly to that section.

Revision Notes

- Updated to include formulary statement (The listed GCNS may not be an indication of TX Medicaid Formulary coverage. To learn the current formulary coverage, visit TxVendorDrug.com/formulary/formulary-search.) on each ‘Drug Requiring PA’ table
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Drugs Requiring Prior Authorization

The listed GCNS may not be an indication of TX Medicaid Formulary coverage. To learn the current formulary coverage, visit TxVendorDrug.com/formulary/formulary-search.

<table>
<thead>
<tr>
<th>Label Name</th>
<th>GCN</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALTABAX 1% OINTMENT</td>
<td>98373</td>
</tr>
</tbody>
</table>
1. Does the client have a diagnosis of impetigo in the past 30 days?
   [ ] Yes (Go to #2)
   [ ] No (Deny)

2. Manual step – Does the client have a sensitivity or allergy to mupirocin in the past 30 days?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)
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Clinical Criteria Logic Diagram

Step 1
Does the client have a diagnosis of impetigo in the past 30 days?

No

Deny Request

Yes

Step 2 (Manual)
Does the client have a sensitivity or allergy to mupirocin in the past 30 days?

No

Deny Request

Yes

Approve Request (365 days)
## Step 1 (diagnosis of impetigo)

**Required diagnosis:** 1  
**Look back timeframe:** 30 days

<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>L0100</td>
<td>IMPETIGO, UNSPECIFIED</td>
</tr>
<tr>
<td>L0101</td>
<td>NON-BULLOUS IMPETIGO</td>
</tr>
<tr>
<td>L011</td>
<td>IMPETIGINIZATION OF OTHER DERMATOSES</td>
</tr>
<tr>
<td>L0103</td>
<td>BULLOUS IMPETIGO</td>
</tr>
<tr>
<td>L0109</td>
<td>OTHER IMPETIGO</td>
</tr>
<tr>
<td>L0102</td>
<td>BOCKHART'S IMPETIGO</td>
</tr>
</tbody>
</table>
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Clinical Criteria References


# Publication History

The Publication History records the publication iterations and revisions to this document. Notes for the *most current revision* are also provided in the **Revision Notes** on the first page of this document.

<table>
<thead>
<tr>
<th>Publication Date</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/31/2011</td>
<td>Initial publication and posting to website</td>
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</table>
| 10/13/2011       | • Added a new section to specify the drugs requiring prior authorization  
|                  | • In the "Clinical Edit Criteria Supporting Tables" section, revised table to specify the diagnosis codes pertinent to step 1 of the logic diagram  
|                  | • Modified the criteria logic and logic diagram to identify the steps that are executed manually |
| 04/03/2015       | • Updated to include ICD-10s |
| 05/27/2016       | • Updated references, page 6 |
| 03/21/2019       | • Updated to include formulary statement (The listed GCNS may not be an indication of TX Medicaid Formulary coverage. To learn the current formulary coverage, visit TxVendorDrug.com/formulary/formulary-search.) on each ‘Drug Requiring PA’ table |