

EVH Clinical Guideline 5096.CC for Qutenza (capsaicin) 8% patch

Guideline Number: EVH_CG_5096.CC	<u>Applicable Codes</u>	
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Original Date: April 2024	Last Revised Date: March 2026	Implementation Date: June 2026

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STATEMENT

General Information

- *It is the policy of the Health Plan to maintain a prior authorization process that promotes appropriate utilization of specific drugs with potential for misuse or limited indications. This process involves a review using Food and Drug Administration (FDA) criteria to make a determination of Medical Necessity and approval by the Medical Policy Committee.*
- *If the established criteria are not met, the request is referred to a Medical Director for review, if required for the plan and level of request.*

Purpose

The purpose of this guideline is to define the prior authorization process for the following drug: Qutenza (capsaicin) 8% patch.

Scope

This guideline applies to all practitioners who are involved in providing the requested drug. This guideline is specific to the Health Plan's medical benefit.

INITIAL REVIEW CRITERIA

The request must meet all of the criteria listed below.

- Must be age 18 or older
- Must have one of the following diagnoses:
 - Post-herpetic neuralgia (PHN)
 - Neuropathic pain associated with diabetic peripheral neuropathy (DPN) of the feet
- Must not be using more than four patches every three months
- Must be administered in a provider's office
- **For PHN:** Must have a trial and failure the following:
 - Capsaicin topical cream (available over the counter)
 - Either a tricyclic antidepressant (e.g., amitriptyline) OR gabapentin
- **For DPN:** Must have a trial and failure of the following:
 - Capsaicin topical cream (available over the counter)
 - Gabapentin

REAUTHORIZATION CRITERIA

All prior authorization renewals are reviewed on an annual basis to determine the Medical Necessity for continuation of therapy. The request must meet all of the criteria listed below.

- Must not be receiving the requested medication more often than every three months
- Must have chart note documentation from the prescriber that the member's condition has improved based upon the prescriber's assessment while on therapy

APPROVAL DURATIONS

Initial Authorization	Up to one year
Reauthorization	Same as initial

CODING AND STANDARDS

Codes

Code	Brand	Description
J7336	QUTENZA	CAPSAICIN 8% PATCH, PER SQUARE CENTIMETER

Applicable Lines of Business

☐	CHIP (Children's Health Insurance Program)
☐	Commercial
☐	Exchange/Marketplace
☒	Medicaid
☐	Medicare Advantage

BACKGROUND

Qutenza (capsaicin) 8% patch is indicated for the management of pain associated with post-herpetic neuralgia and neuropathic pain associated with diabetic peripheral neuropathy (DPN) of the feet. Up to four patches can be applied for 60 minutes by, or under the close supervision

of, a doctor. Treatment may be repeated every three months or as warranted by the return of pain (but not more frequently than every three months).

POLICY HISTORY

Date	Summary
March 2026	• Annual review
April 2024	• New guideline

LEGAL AND COMPLIANCE

Guideline Approval

Committee

Reviewed / Approved by Evolent Administrative Services Medical Policy Committee

Disclaimer

Evolent Clinical Guidelines do not constitute medical advice. Treating health care professionals are solely responsible for diagnosis, treatment, and medical advice. Evolent uses Clinical Guidelines in accordance with its contractual obligations to provide utilization management. Coverage for services varies for individual members according to the terms of their health care coverage or government program. Individual members' health care coverage may not utilize some Evolent Clinical Guidelines. Evolent clinical guidelines contain guidance that requires prior authorization and service limitations. A list of procedure codes, services or drugs may not be all inclusive and does not imply that a service or drug is a covered or non-covered service or drug. Evolent reserves the right to review and update this Clinical Guideline in its sole discretion. Notice of any changes shall be provided as required by applicable provider agreements and laws or regulations. Members should contact their Plan customer service representative for specific coverage information.

Evolent Clinical Guidelines are comprehensive and inclusive of various procedural applications for each service type. Our guidelines may be used to supplement Medicare criteria when such criteria is not fully established. When Medicare criteria is determined to not be fully established, we only reference the relevant portion of the corresponding Evolent Clinical Guideline that is applicable to the specific service or item requested in order to determine medical necessity.

REFERENCES

1. Qutenza [package insert]. Morristown, NJ: Averitas Pharma, Inc; July 2024.
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3. Price R, Smith D, et al. Oral and Topical Treatment of Painful Diabetic Polyneuropathy: Practice Guideline Update Summary Report of the AAN Guideline Subcommittee. Neurology Jan 2022, 98 (1) 31-43; DOI: 10.1212/WNL.00000000000013038
4. Hempenstall K, Nurmikko TJ, Johnson RW, A’Hern RP, Rice AS. Analgesic therapy in postherpetic neuralgia: a quantitative systematic review. PLoS Med. 2005 Jul;2(7):e164. Doi: 10.1371/journal.pmed.0020164. Epub 2005 Jul 26. PMID: 16013891; PMCID: PMC1181872