Drug Coverage Policy

Effective Date……02/01/2026
Coverage Policy Number…… DQM015
Policy Title…….Anzupgo Drug Quantity Management Policy – Per Days

Dermatology – Anzupgo Drug Quantity Management Policy – Per Days

- Anzupgo® (delgocitinib 2% cream – LEO)

INSTRUCTIONS FOR USE
The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment where appropriate and have discretion in making individual coverage determinations. Where coverage for care or services does not depend on specific circumstances, reimbursement will only be provided if a requested service(s) is submitted in accordance with the relevant criteria outlined in the applicable Coverage Policy, including covered diagnosis and/or procedure code(s). Reimbursement is not allowed for services when billed for conditions or diagnoses that are not covered under this Coverage Policy (see "Coding Information" below). When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted for services that are not accompanied by covered code(s) under the applicable Coverage Policy will be denied as not covered. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Overview
Anzupgo, a Janus kinase (JAK) inhibitor, is indicated for the topical treatment of moderate to severe **chronic hand eczema** in patients ≥ 18 years of age who have had an inadequate response to topical corticosteroids or for whom topical corticosteroids are not advisable.[1]
Limitations of Use: Use of Anzupgo in combination with other JAK inhibitors or potent immunosuppressants is not recommended.

Dosing
Anzupgo is applied twice daily (BID) as a thin layer to affected areas of skin only on the hands and wrists.[1] Do not use more than 30 grams per 2 weeks or 60 grams per month.

Availability
Anzupgo is available as a 2% cream supplied in 30 gram tubes.[1]

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POLICY STATEMENT
This Drug Quantity Management program has been developed to promote the safe, effective, and economic use of Anzupgo. If the Drug Quantity Management rule is not met for the requested medication at the point of service, coverage will be determined by the Criteria below. All approvals are provided for 1 year in duration. Meeting Drug Quantity Management Program Criteria does not satisfy any other prior authorization or medical necessity criteria requirements.

Drug Quantity Limits

Product	Strength and Form	Retail Maximum Quantity per 30 Days	Home Delivery Maximum Quantity per 90 days
Anzupgo® (delgocitinib 2% cream)	30 gram tube	30 grams	90 grams

Exceptions to the quantity limits listed above are covered as medically necessary when the following criteria is met. Any other exception is considered not medically necessary.

CRITERIA
Anzupgo 2% cream
1. If a patient requires an additional quantity to treat moderate to severe chronic hand eczema on the hands and/or wrists only, approve 60 grams per 30 days at retail and 180 grams per 90 days at home delivery.

References

1. Anzupgo® cream [prescribing information]. Madison, NJ; LEO: July 2025.

Revision Details

Type of Revision	Summary of Changes	Date
New	New policy.	02/01/2026

The policy effective date is in force until updated or retired.