

**Clinical Policy: Luliconazole Cream (Luzu)**

Reference Number: CP.PMN.166

Effective Date: 08.28.18

Last Review Date: 02.26

Line of Business: Commercial, HIM, Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

**Description**

Luliconazole cream (Luzu<sup>®</sup>) is an azole antifungal.

**FDA Approved Indication(s)**

Luzu is indicated for the topical treatment of interdigital tinea pedis, tinea cruris, and tinea corporis caused by the organisms *Trichophyton rubrum* and *Epidermophyton floccosum*.

**Policy/Criteria**

*Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.*

It is the policy of health plans affiliated with Centene Corporation<sup>®</sup> that luliconazole and Luzu are **medically necessary** when the following criteria are met:

**I. Initial Approval Criteria****A. Tinea Infections** (must meet all):

1. Diagnosis of tinea pedis, tinea cruris, or tinea corporis;
2. Age  $\geq$  2 years;
3. Failure of two formulary topical azole antifungal products (e.g., clotrimazole, ketoconazole, econazole, *see Appendix B*), unless clinically significant adverse effects are experienced or all are contraindicated;\*
- \*For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395*
4. If request is for brand Luzu, member must use generic luliconazole, unless contraindicated or clinically significant adverse effects are experienced;
5. Dose does not exceed one tube (60 g) per month.

**Approval duration: 4 weeks**

**B. Other diagnoses/indications** (must meet all):

1. If request is for brand Luzu, member must use generic luliconazole, unless contraindicated or clinically significant adverse effects are experienced;
2. One of the following (a or b):
  - a. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (i or ii):
    - i. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of

- business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
- ii. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
- b. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

## **II. Continued Therapy**

### **A. Tinea Infections**

1. Re-authorization is not permitted. Members must meet the initial approval criteria.

**Approval duration: Not applicable**

### **B. Other diagnoses/indications (must meet all):**

1. If request is for brand Luzu, member must use generic luliconazole, unless contraindicated or clinically significant adverse effects are experienced;
2. One of the following (a or b):
  - a. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (i or ii):
    - i. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
    - ii. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
  - b. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

## **III. Diagnoses/Indications for which coverage is NOT authorized:**

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid, or evidence of coverage documents.

## **IV. Appendices/General Information**

*Appendix A: Abbreviation/Acronym Key*

FDA: Food and Drug Administration

*Appendix B: Therapeutic Alternatives*

*This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.*

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
clotrimazole cream (Desenex <sup>®</sup> , Lotrim <sup>®</sup> AF, Pro-Ex <sup>®</sup> Antifungal, Shopko <sup>®</sup> Athletes Foot), solution, ointment (Alevazol <sup>®</sup> )	Apply to affected area BID	Varies
econazole cream, foam (Ecoza <sup>®</sup> )	Apply to affected area QD	Varies
ketoconazole cream	Apply to affected and immediate surrounding area QD	Varies
miconazole (Lotromin AF, Cruex <sup>®</sup> , Desenex <sup>®</sup> , Micro Guard <sup>®</sup> , Zeasorb-AF <sup>®</sup> )	Apply to affected area BID	Varies
oxiconazole cream, lotion (Oxistat <sup>®</sup> )	Apply to affected area QD – BID	Varies
Ertaczo <sup>®</sup> (sertaconazole cream)	Tinea pedis: apply to affected area BID	Varies
Exelderm <sup>®</sup> (sulconazole cream, solution)	Tinea corporis/tinea cruris: apply to affected and surrounding area QD – BID Tinea pedis (cream): apply to affected area BID	Varies

*Therapeutic alternatives are listed as Brand name<sup>®</sup> (generic) when the drug is available by brand name only and generic (Brand name<sup>®</sup>) when the drug is available by both brand and generic.*

*Appendix C: Contraindications/Boxed Warnings*

None reported

**V. Dosage and Administration**

Indication	Dosing Regimen	Maximum Dose
Tinea pedis	Apply to affected and immediate surrounding area(s) QD for 2 weeks	Varies
Tinea cruris, tinea corporis	Apply to affected skin and immediate surrounding area(s) QD for 1 week	Varies

**VI. Product Availability**

Cream (1%): 60 g

**VII. References**

1. Luzu Prescribing Information. Bridgewater, NJ: Valeant Pharmaceuticals; April 2020. Available at: <http://www.luzurx.com/>. Accessed October 23, 2025.

2. Micromedex<sup>®</sup> Healthcare Series [Internet database]. Greenwood Village, Colo: Thomson Healthcare. Updated periodically. Accessed November 7, 2025.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q 2022 annual review: no significant changes; references reviewed and updated.	09.23.21	02.22
Template changes applied to other diagnoses/indications and continued therapy section.	10.04.22	
1Q 2023 annual review: added requirement for use of generic luliconazole for brand Luzu requests; references reviewed and updated.	10.13.22	02.23
1Q 2024 annual review: no significant changes; references reviewed and updated.	10.24.23	02.24
1Q 2025 annual review: added luliconazole to “luliconazole and Luzu are medically necessary when the following criteria are met” standard template language as generic requires prior authorization; references reviewed and updated.	11.06.24	02.25
1Q 2026 annual review: no significant changes; references reviewed and updated. Added step therapy bypass for IL HIM per IL HB 5395.	10.23.25	02.26

### **Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to

applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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**Note:**

**For Medicaid members**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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