Clinical Policy: Neomycin/Fluocinolone Cream (Neo-Synalar)

Reference Number: CP.PMN.167
Effective Date: 12.01.18
Last Review Date: 11.26
Line of Business: Commercial, HIM/ICHRA, Medicaid Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Neomycin/fluocinolone cream (Neo-Synalar®) is a combination antibacterial and corticosteroid topical cream.

FDA Approved Indication(s)

Neo-Synalar is indicated for the treatment of corticosteroid-responsive dermatoses with secondary infection. It has not been demonstrated that this steroid-antibiotic combination provides greater benefit than the steroid component alone after 7 days of treatment.

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® that Neo-Synalar is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Dermatoses (must meet all)**:**

1. Diagnosis of a corticosteroid-responsive dermatosis (e.g., eczema, psoriasis, poison ivy, oak, or sumac, insect bites, atopic dermatitis, seborrheic dermatitis);
2. Failure of a formulary topical antibacterial product at up to maximally indicated doses (*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
3. Dose does not exceed (a and b):
   a. Two tubes per treatment course;
   b. 120 g per treatment course.

Approval duration: 14 days

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. 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 (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) 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/ICHRA, and CP.PMN.255 for Medicaid; or

b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) 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/ICHRA, and CP.PMN.16 for Medicaid; or

2. 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/ICHRA, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Dermatoses

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

Approval duration: Not applicable

B. Other diagnoses/indications (must meet 1 or 2):

1. 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 (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) 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/ICHRA, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) 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/ICHRA, and CP.PMN.16 for Medicaid; or
2. 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/ICHRA, 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/ICHRA, 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
neomycin/polymyxin B/bacitracin ointment (Neosporin®)	Apply a thin film (amount equal to the surface area of the fingertip) to the affected area 1 to 3 times daily. Continue for full course of treatment; therapy should be limited to 7 days	See regimen
bacitracin/polymyxin B ointment (Polysporin®)	Apply as a thin film (amount equal to the surface area of the fingertip) or a light dusting of powder to the affected area 1 to 3 times daily. Continue for full course of treatment; therapy should be limited to 7 days	See regimen

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

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): hypersensitivity to any components of the preparation, use in the external auditory canal if the eardrum is perforated
- Boxed warning(s): none reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Dermatoses with secondary infection	Apply a thin film to affected area 2 to 4 times daily	4 applications/day

VI. Product Availability

Cream (60 g): 0.5% neomycin/0.025% fluocinolone

VII. References

1. Neo-Synalar Prescribing Information. Buena, NJ: Medimetriks Pharmaceuticals Inc.; March 2026. Available at: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=1141956e-8a4c-4f80-95d1-f15bdb57fdf6. Accessed July 10, 2026.
2. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2026. Available at: https://www.clinicalkey.com/pharmacology/. Accessed July 22, 2026.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
4Q 2022 annual review: no significant changes; revised Cortisporin redirection to a formulary topical antibacterial product as Cortisporin topical ointment is no longer on market; references	07.20.22	11.22

Reviews, Revisions, and Approvals	Date	P&T Approval Date
reviewed and updated. Template changes applied to other diagnoses/indications.		
4Q 2023 annual review: no significant changes; references reviewed and updated.	07.05.23	11.23
4Q 2024 annual review: no significant changes; for section VI, removed "15 g" package size as product is no longer on market; references reviewed and updated.	07.19.24	11.24
4Q 2025 annual review: no significant changes; added step therapy bypass for IL HIM per IL HB 5395; references reviewed and updated.	07.11.25	11.25
4Q 2026 annual review: no significant changes; added ICHRA line of business; references reviewed and updated.	07.10.26	11.26

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.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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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