Clinical Policy: Betamethasone Dipropionate Spray (Sernivo)

Reference Number: IL.PMN.182
Effective Date: 1.1.20
Last Review Date: 10.25.26
Line of Business: YouthCare HealthChoice Medicaid

Revision Log

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

Description

Betamethasone dipropionate 0.05% spray (Sernivo®) is a topical corticosteroid.

FDA Approved Indication(s)

Sernivo is indicated for the treatment of mild to moderate plaque psoriasis (PsO) in patients 18 years of age and older.

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 Sernivo is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Plaque Psoriasis (must meet all)**:**

1. Diagnosis of PsO;
2. Age ≥ 18 years;
3. Failure of a medium to ultra-high potency topical corticosteroid (See Appendix B) unless contraindicated or clinically significant adverse effects are experienced;
4. Failure of calcipotriene, unless contraindicated or clinically significant adverse effects are experienced;
5. Dose does not exceed 120 mL every 4 weeks.

Approval duration: One month

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) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: 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.PMN.53 for Medicaid.

II. Continued Therapy

A. Plaque Psoriasis (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed 120 mL every 4 weeks.

Approval duration: Up to one month of total treatment (a single continuous course of therapy up to 4 weeks is recommended)

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) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: 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.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.PMN.53 for Medicaid.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration
PsO: plaque psoriasis

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
calcipotriene (Dovonex®) cream, ointment, solution	Apply topically to the affected area(s) BID	100 g/week
Ultra High Potency Topical Corticosteroids		
augmented betamethasone dipropionate 0.05% (Diprolene®, Alphatrex®) ointment, gel	Apply topically to the affected area(s) BID	Should not be used for longer than 2 consecutive weeks
clobetasol propionate 0.05% (Temovate®, Temovate E®) cream, ointment, gel, solution		
diflorasone diacetate 0.05% (Apexicon®) ointment		
halobetasol propionate 0.05% (Ultravate®) cream, ointment		
High Potency Topical Corticosteroids		
augmented betamethasone dipropionate 0.05% (Diprolone®, Diprolene® AF) cream, lotion	Apply topically to the affected area(s) BID	Should not be used for longer than 2 consecutive weeks
betamethasone dipropionate 0.05% ointment		
desoximetasone (Topicort®) 0.25%, 0.05% cream, ointment, gel		
diflorasone 0.05% (Apexicon E®) cream		
fluocinonide acetonide 0.05% cream, ointment, gel, solution		
triamcinolone acetonide 0.5% (Aristocort®, Kenalog®) cream, ointment		
Medium/Medium to High Potency Topical Corticosteroids		
betamethasone dipropionate 0.05% cream	Apply topically to the affected area(s) BID	Should not be used for longer than 2 consecutive weeks
desoximetasone 0.05% (Topicort®) cream, ointment, gel		
fluocinolone acetonide 0.025% (Synalar®) cream, ointment		
fluticasone propionate 0.05% (Cutivate®) cream		

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
mometasone furoate 0.1% (Elocon®) cream, lotion, ointment		
triamcinolone acetonide 0.1%, 0.25%,0.5% (Aristocort®, Kenalog®) cream, ointment		

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
None reported

V. Dosage and Administration

Drug Name	Dosing Regimen	Maximum Dose
Betamethasone dipropionate 0.05% (Sernivo)	Apply spray topically to affected areas BID for up to 4 weeks. Avoid use on face, scalp, axilla, groin, or other intertriginous areas.	Not applicable

VI. Product Availability

Spray: 0.05% (0.5 mg betamethasone/g)

VII. References

1. 1. Sernivo Prescribing Information. San Antonio, TX: DPT Laboratories; September 2025. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2026/208079Orig1s004lbl.pdf. Accessed July 16, 2026.
2. 2. Elmets CA, Korman NJ, Prater EF, et al. Joint AAD-NPF Guidelines of care for the management and treatment of psoriasis with topical therapy and alternative medicine modalities for psoriasis severity measures. J Am Acad Dermatol 2021;84:432-70.
3. 3. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2026. Available at: https://www.clinicalkey.com/pharmacology/. Accessed July 16, 2026.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
New policy created, adapted CP.PMN.182 Betamethasone dipropionate (Sernivo) policy.	12.17.19	1.7.20
Q4 2020 annual review: no significant changes; references reviewed and updated.	12.5.20	
Q1 2022 annual review; no significant changes; references reviewed	3.31.22	

Reviews, Revisions, and Approvals	Date	P&T Approval Date
4Q 2023 annual review: no significant changes; references reviewed and updated. Template changes applied to other diagnoses/indications and continued therapy section.	10.18.23	
4Q 2024 annual review: no significant changes; for product availability section, updated strength per prescriber information; references reviewed and updated.	11.5.24	
4Q2025 Annual review: no changes.	12.8.25	
4Q 2026 annual review: no significant changes; references reviewed and updated.	10.25.26	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.

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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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