### Acne-Rosacea
**Effective 02/01/2021**

<table>
<thead>
<tr>
<th>Plan</th>
<th>Program Type</th>
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<tbody>
<tr>
<td>☒ MassHealth</td>
<td>☐ Prior Authorization</td>
</tr>
<tr>
<td>☐ Commercial/Exchange</td>
<td>☐ Quantity Limit</td>
</tr>
<tr>
<td>☒ Pharmacy Benefit</td>
<td>☒ Step Therapy</td>
</tr>
<tr>
<td>☐ Medical Benefit (NLX)</td>
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<thead>
<tr>
<th>Specialty Limitations</th>
<th>N/A</th>
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<tr>
<th>Specialty Medications</th>
<th>Non-Specialty Medications</th>
<th>Medical Specialty Medications (NLX)</th>
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<tbody>
<tr>
<td>All Plans</td>
<td>Phone: 866-814-5506</td>
<td>Fax: 866-249-6155</td>
</tr>
<tr>
<td>MassHealth</td>
<td>Phone: 877-433-7643</td>
<td>Fax: 866-255-7569</td>
</tr>
<tr>
<td>Commercial</td>
<td>Phone: 800-294-5979</td>
<td>Fax: 888-836-0730</td>
</tr>
<tr>
<td>Exchange</td>
<td>Phone: 855-582-2022</td>
<td>Fax: 855-245-2134</td>
</tr>
<tr>
<td>All Plans</td>
<td>Phone: 844-345-2803</td>
<td>Fax: 844-851-0882</td>
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<tr>
<th>Exceptions</th>
<th>N/A</th>
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## Overview
Prescriptions that meet the initial step therapy requirements will adjudicate automatically at the point of sale. If the prescription does not meet the initial step therapy requirements, the prescription will deny with a message indicating that prior authorization (PA) is required. Refer to the criteria below and submit a PA request for the members who do not meet the initial step therapy requirements at the point of sale.

### Initial Step-Therapy Requirements:
**First-Line:** Medications listed on first-line are covered without prior-authorization.
**Second-Line:** Second-line medications will pay if the member has filled at least two different first-line medications or a second-line medication within the past 180 days.

### Coverage Guidelines

<table>
<thead>
<tr>
<th>Mediations for Acne Vulgaris</th>
<th>FIRST-LINE</th>
<th>SECOND-LINE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Topical Anti-infectives:</strong></td>
<td>OTC benzoyl peroxide</td>
<td>Azelex (azelaic acid) 20% cream</td>
</tr>
<tr>
<td>Generic benzoyl peroxide (various formulations)</td>
<td>Generic clindamycin 1%</td>
<td>Aczone (dapsone) 7.5% gel</td>
</tr>
<tr>
<td>Generic erythromycin 2%</td>
<td>Generic sulfacetamide 10% &amp; sulfur 5%</td>
<td>Dapsone 5% gel</td>
</tr>
<tr>
<td>Generic sulfacetamide 10%</td>
<td><strong>Topical Retinoids:</strong></td>
<td>Tazarotene 0.1% cream</td>
</tr>
<tr>
<td><strong>Topical Retinoids:</strong></td>
<td>Generic tretinoin cream (0.05% &amp; 0.1%)</td>
<td>Differin (adapalene) 0.1% lotion</td>
</tr>
<tr>
<td>Generic tretinoin gel (0.01%, 0.025% &amp; 0.1%)</td>
<td>Tazarotene 0.05% cream</td>
<td>Tazorac (tazarotene) 0.05% cream</td>
</tr>
</tbody>
</table>
If a member does not meet the initial step therapy requirements, then approval of a second-line medication will be granted if the member meets the following criteria:

**Azelex cream & Aczone 7.5% gel & dapsone 5% gel**
1. Patient must have a diagnosis of acne vulgaris (comedonal acne, cystic acne, etc.) or rosacea **AND**
2. Patient has had a documented inadequate response, side effect, or allergy to at least two (2) different generic topical anti-infective agents used separately or together (i.e., clindamycin, erythromycin, benzoyl peroxide, sulfaacetamide, or sodium sulfaacetamide/sulfur)

**Atralin, adapalene 0.3% gel, adapalene 0.1% cream, Differin 0.1% lotion, tretinoin microsphere 0.04%, 0.1% gel**
1. Patient must have a diagnosis of ichthyosis, hyperkeratosis, acne vulgaris (comedonal acne, cystic acne, etc.), or rosacea **AND**
2. Patient has had a documented inadequate response, side effect, or allergy to a **preferred** generic tretinoin cream or gel OR Differin OTC 0.1% gel.

**Tazorac cream/gel 0.05%, tazarotene 0.1% cream & Fabior foam**
1. Patient must have a diagnosis of plaque psoriasis **OR**
1. Patient must have a diagnosis of acne vulgaris (comedonal acne, cystic acne, etc.), or rosacea **AND**
2. Patient has had a documented inadequate response, side effect, or allergy to a **preferred** generic tretinoin cream or gel OR Differin OTC 0.1% gel.

**Azelaic acid 15% Gel, metronidazole 1% and ivermectin 1%**
1. Patient must have a diagnosis of rosacea **AND**
2. Patient has had a documented inadequate response, side effect, or allergy to generic metronidazole 0.75% gel, lotion, or cream

**Limitations**
1. Approvals will be granted for 12 months.
2. All prescriptions for topical Retinoids will require PA for members 26 years of age and older.

**References**
2. Erygel (erythromycin) [prescribing information]. Newtown, PA: Prestium Pharma; August 2015
3. Plexion (sodium sulfacetamide/sulfur) cleanser [prescribing information]. Houston, TX: Brava Pharmaceuticals LLC; January 2014
5. Altreno (tretinoin) [prescribing information]. Bridgewater, NJ: Valeant Pharmaceuticals North America LLC; August 2018.
6. Differin Gel 0.1% (adapalene) [prescribing information]. Fort Worth, TX: Galderma; June 2018.
7. Azelex (azelaic acid) [prescribing information]. Irvine, CA: Allergan; September 2015.
8. Aczone 5% Gel (dapsone) [prescribing information]. Irvine, CA: Allergan; May 2018.
10. Differin Gel 0.3% (adapalene) [prescribing information]. Fort Worth, TX: Galderma; December 2013.
11. Differin Lotion (adapalene) [prescribing information]. Fort Worth, TX: Galderma; April 2013.
13. Tazorac gel (tazarotene) [prescribing information]. Irvine, CA: Allergan, Inc; April 2018.
14. Flagyl Cream (metronidazole) [product monograph]. Laval, Quebec, Canada: Sanofi-Aventis Canada Inc; August 2018.
15. MetroLotion (metronidazole) [prescribing information]. Fort Worth, TX: Galderma Laboratories; February 2017.
18. Finacea (azelaic acid) gel [prescribing information]. Whippany, NJ: Bayer HealthCare Pharmaceuticals; August 2018.
19. Ivermectin (Soolantra) (ivermectin) [prescribing information]. Fort Worth, TX: Galderma Laboratories, L.P.; April 2018.

Review History
03/21/05 – Reviewed
02/27/06 – Updated
03/05/07 – Updated
12/20/07 – Updated
01/03/08 – Updated
02/25/08 – Updated
02/23/09 – Updated
09/02/09 – Avita note
02/22/10 – Updated
06/18/10 – Adapalene gel
07/23/10 – Adapalene cr
08/02/10 – Tretin-x
02/28/11 – Reviewed
02/27/12 – Reviewed
02/25/13 – Approvable dx question
04/08/13 – Updated
07/29/13 – Updated
08/26/13 – Updated
10/21/13 – Updated
11/04/13 – Updated
01/13/14 – Retin-A micro gel & Metrogel 1% generics
02/24/14 – Updated
05/05/14 – Differin generic
02/23/15 – Reviewed
09/18/17 – Updated
02/26/18 – Updated
02/20/19 – Updated
07/2019 – Removed references to Finacea foam (nonformulary)
01/20/2021 – Reviewed and Updated. Separated out Comm/Exch vs. MH criteria. Effective 02/01/21.

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