# Acne-Rosacea

**Effective 01/01/2022**

<table>
<thead>
<tr>
<th>Plan</th>
<th>Program Type</th>
</tr>
</thead>
<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>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Specialty Limitations</th>
<th>Specialty Medications</th>
<th>Non-Specialty Medications</th>
<th>Medical Specialty Medications (NLX)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☒ Pharmacy Benefit</td>
<td>N/A</td>
<td>All Plans</td>
<td>Phone: 866-814-5506</td>
<td>Fax: 866-249-6155</td>
</tr>
<tr>
<td>☐ Medical Benefit (NLX)</td>
<td></td>
<td>MassHealth</td>
<td>Phone: 877-433-7643</td>
<td>Fax: 866-255-7569</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Commercial</td>
<td>Phone: 800-294-5979</td>
<td>Fax: 888-836-0730</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Exchange</td>
<td>Phone: 855-582-2022</td>
<td>Fax: 855-245-2134</td>
</tr>
</tbody>
</table>

| Exception | N/A |

## 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>Medications for Acne Vulgaris</th>
<th><strong>FIRST-LINE</strong></th>
<th><strong>SECOND-LINE</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Topical Anti-infectives:</strong></td>
<td></td>
<td>Topical Anti-infectives:</td>
</tr>
<tr>
<td>OTC benzoyl peroxide</td>
<td></td>
<td>Aczone (dapsone) 7.5% gel</td>
</tr>
<tr>
<td>Generic benzoyl peroxide (various formulations)</td>
<td></td>
<td>Dapsone 5% gel</td>
</tr>
<tr>
<td>Generic clindamycin 1%</td>
<td></td>
<td><strong>Topical Retinoids:</strong></td>
</tr>
<tr>
<td>Generic erythromycin 2%</td>
<td></td>
<td>Atralin (tretinoin) 0.05% gel</td>
</tr>
<tr>
<td>Generic sulfacetamide 10% &amp; sulfur 5%</td>
<td></td>
<td>adapalene 0.3% gel (RX)</td>
</tr>
<tr>
<td>Generic sulfacetamide 10%</td>
<td></td>
<td>adapalene 0.1% cream (RX)</td>
</tr>
<tr>
<td><strong>Topical Retinoids:</strong></td>
<td></td>
<td>Differin (adapalene) 0.1% <a href="#">lotion</a></td>
</tr>
<tr>
<td>Generic tretinoin cream (0.05% &amp; 0.1%)</td>
<td></td>
<td>Tazarotene 0.1% cream</td>
</tr>
<tr>
<td>Generic tretinoin gel (0.01%, 0.025% &amp; 0.1%)</td>
<td></td>
<td>Tazorac (tazarotene) 0.05% cream</td>
</tr>
<tr>
<td>Differin OTC (adapalene) 0.1% Gel</td>
<td></td>
<td>Tazorac (tazarotene) 0.05% &amp; 0.1% gel</td>
</tr>
<tr>
<td></td>
<td></td>
<td>tretinoin microsphere 0.04%, 0.1% gel</td>
</tr>
</tbody>
</table>
FIRST-LINE | SECOND-LINE
---|---
**Medications for Acne Rosacea** | Fabior (tazarotene) 0.1% aerosol foam
Generic metronidazole 0.75% cream, gel, lotion | metronidazole 1% gel
Noritate (metronidazole) 1% cream | azelaic acid 15% gel
Ivermectin (Soolantra) 1% cream

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:

**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, sulfacetamide, or sodium sulfacetamide/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%, Tazorac 0.1% gel, tazarotene 0.1% cream & Fabior foam**
1. Patient must have a diagnosis of plaque psoriasis OR
2. Patient must have a diagnosis of acne vulgaris (comedonal acne, cystic acne, etc.), or rosacea AND
3. 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. Initial approvals and reauthorizations 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. Aczone 5% Gel (dapsone) [prescribing information]. Irvine, CA: Allergan; May 2018
9. Differin Gel 0.3% (adapalene) [prescribing information]. Fort Worth, TX: Galderma; December 2013.
10. Differin Lotion (adapalene) [prescribing information]. Fort Worth, TX: Galderma; April 2013.
11. Tazorac cream (tazarotene) [prescribing information]. Irvine, CA: Allergan, Inc; July 2017
12. Tazorac gel (tazarotene) [prescribing information]. Irvine, CA: Allergan, Inc; April 2018.
13. Flagyl Cream (metronidazole) [product monograph]. Laval, Quebec, Canada: Sanofi-Aventis Canada Inc; August 2018.
14. MetroLotion (metronidazole) [prescribing information]. Fort Worth, TX: Galderma Laboratories; February 2017.
17. Finacea (azelaic acid) gel [prescribing information]. Whippany, NJ: Bayer HealthCare Pharmaceuticals; August 2018
18. 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
01/3/08 – 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)
11/18/2020 – Removed references to Azelex; removed Azelex from ST criteria to NF for 1/1/2021 strategy for Comm/Exch. Separated out criteria for MH vs. Comm/Exch
11/17/2021 – Reviewed and Updated; added Tazorac 0.1% gel to Coverage requirements. Effective 01/01/2022

Disclaimer
AllWays Health Partners complies with applicable federal civil rights laws and does not discriminate or exclude people on the basis of race, color, national origin, age, disability, or sex.