Mass General Brigham
Health Plan

Acne and Rosacea Medications
Effective 01/01/2026

Plan	☐ MassHealth UPPL ☒Commercial/Exchange	**Program Type**	☐ Prior Authorization ☐ Quantity Limit ☒ Step Therapy
Benefit	☒ Pharmacy Benefit ☐ Medical Benefit		
Specialty Limitations	N/A		
Contact Information	**Medical Benefit** **Pharmacy Benefit**	Phone: 833-895-2611 Phone: 800-711-4555	Fax: 888-656-6671 Fax: 844-403-1029
Exceptions	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.

	FIRST-LINE	SECOND-LINE
Medications for Acne Vulgaris	**Topical Anti-infectives:** OTC benzoyl peroxide Generic benzoyl peroxide (various formulations) Generic clindamycin 1% Generic erythromycin 2% Generic sulfacetamide 10% & sulfur 5% Generic sulfacetamide 10%	**Topical Anti-infectives:** Aczone (dapsone) 7.5% gel Dapsone 5% gel
	****Topical Retinoids:** Generic tretinoin cream (0.05% & 0.1%) Generic tretinoin gel (0.01%, 0.025% & 0.1%) Differin OTC (adapalene) 0.1% Gel	**Topical Retinoids:** Atralin (tretinoin) 0.05% gel adapalene 0.3% gel (RX) adapalene 0.1% cream (RX) Tazarotene 0.1% cream Tazorac (tazarotene) 0.05% cream Tazorac (tazarotene) 0.05% gel tretinoin microsphere 0.04%, 0.1% gel
Medications for Acne Rosacea	Generic metronidazole 0.75% cream, gel, lotion	metronidazole 1% gel 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:

Coverage Guidelines
Authorization may be granted for members new to the plan within the past 90 days who are currently receiving treatment with the requested medication excluding when the product is obtained as samples or via manufacturer's patient assistance programs
OR
Authorization may be granted for members when all the following criteria have been met:

Dapsone 7.5% gel & dapsone 5% gel
1. Member has a diagnosis of acne vulgaris (comedonal acne, cystic acne, etc.) or rosacea
2. Member has had an inadequate response, adverse effect, or contraindication to at least two (2) first-line topical anti-infectives.

Atralin, adapalene 0.3% gel, adapalene 0.1% cream, tretinoin microsphere 0.04%, 0.1% gel
1. Member has a diagnosis of ichthyosis, hyperkeratosis, acne vulgaris (comedonal acne, cystic acne, etc.), or rosacea
2. Member has had an inadequate response, adverse effect, or contraindication to a first-line topical retinoid

Tazorac cream/gel 0.05%, tazarotene 0.1% cream
1. Member meets ONE of the following:
    a. Member has a diagnosis of plaque psoriasis
    b. Members meets BOTH of the following:
        i. Member has a diagnosis of acne vulgaris (comedonal acne, cystic acne, etc.), or rosacea
        ii. Member has had an inadequate response, adverse effect, or contraindication to a first-line topical retinoid

Azelaic acid 15% Gel, metronidazole 1% gel, ivermectin 1%
1. Member has a diagnosis of rosacea
2. Member has had an inadequate response, adverse reaction, or contraindication to generic metronidazole 0.75% gel, lotion, or cream

Limitations
1. Requests for reauthorization will be reviewed against initial criteria.
2. Initial approvals and reauthorizations will be granted for 12 months.
3. All prescriptions for topical Retinoids will require PA for members 26 years of age and older.

References
1. Aczone 5% Gel (dapsone) [prescribing information]. Irvine, CA: Allergan; May 2018.
2. Altreno (tretinoin) [prescribing information]. Bridgewater, NJ: Valeant Pharmaceuticals North America LLC; August 2018.
3. Avita (tretinoin) gel [prescribing information]. Morgantown, WV: Mylan Pharmaceuticals; January 2018.
4. Benzoyl peroxide) [prescribing information]. Scottsdale, AZ: ProGen Inc.; received February 2017.

5. Conde JF, Yelverton CB, Balkrishnan R, et al. Managing rosacea: a review of the use of metronidazole alone and in combination with oral antibiotics. J Drugs Dermatol 2007; 6:495.
6. Differin Gel 0.1% (adapalene) [prescribing information]. Fort Worth, TX: Galderma; June 2018.
7. Differin Gel 0.3% (adapalene) [prescribing information]. Fort Worth, TX: Galderma; December 2013.
8. Erygel (erythromycin) [prescribing information]. Newtown, PA: Prestium Pharma; August 2015
9. Finacea (azelaic acid) gel [prescribing information]. Whippany, NJ: Bayer HealthCare Pharmaceuticals; August 2018
10. Flagyl Cream (metronidazole) [product monograph]. Laval, Quebec, Canada: Sanofi-Aventis Canada Inc; August 2018.
11. Ivermectin (Soolantra) (ivermectin) [prescribing information]. Fort Worth, TX: Galderma Laboratories, L.P.; April 2018.
12. MetroLotion (metronidazole) [prescribing information]. Fort Worth, TX: Galderma Laboratories; February 2017.
13. Metronidazole gel [prescribing information]. Bridgewater, NJ: Valeant; March 2014
14. Noritate (metronidazole) 1% cream [prescribing information]. Bridgewater, NJ: Valeant; March 2018.
15. Ovace Plus (sulfacetamide) foam [prescribing information]. San Antonio, TX: Mission Pharmacal Co; January 2015.
16. Plexion (sodium sulfacetamide/sulfur) cleanser [prescribing information]. Houston, TX: Brava Pharmaceuticals LLC; January 2014
17. Tazorac cream (tazarotene) [prescribing information]. Irvine, CA: Allergan, Inc; July 2017
18. Tazorac gel (tazarotene) [prescribing information]. Irvine, CA: Allergan, Inc; April 2018.
19. Webster GF, Berson D, Stein LF, et al. Efficacy and tolerability of once-daily tazarotene 0.1% gel versus once-daily tretinoin 0.025% gel in the treatment of facial acne vulgaris: a randomized trial. Cutis 2001; 67:4.
20. Wolf JE Jr, Kerrouche N, Arsonnaud S. Efficacy and safety of once-daily metronidazole 1% gel compared with twice-daily azelaic acid 15% gel in the treatment of rosacea. Cutis 2006; 77:3.

Review History

03/21/05 – Reviewed
02/27/06 – Updated
03/05/07 – Updated
12/20/07 – Updated
010/3/08 – 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.
10/08/2025 – Reviewed and updated at September P&T. Removed the following products from the policy as both the brands and generics are moving to nonformulary status: adapalene 0.1% lotion (Differin), tazarotene 0.1% gel (Tazorac), tazarotene 0.1% foam (Fabior), metronidazole 1% cream (Noritate). Updated language for members who are new to the Plan. Updated trial and failure language throughout policy. Effective 1/1/2026.