

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

<b>Plan</b>	<input checked="" type="checkbox"/> MassHealth <input type="checkbox"/> Commercial/Exchange	<b>Program Type</b>	<input type="checkbox"/> Prior Authorization
<b>Benefit</b>	<input checked="" type="checkbox"/> Pharmacy Benefit <input type="checkbox"/> Medical Benefit (NLX)		<input type="checkbox"/> Quantity Limit <input checked="" type="checkbox"/> Step Therapy
<b>Specialty Limitations</b>	N/A		
<b>Contact Information</b>	<b>Specialty Medications</b>		
	All Plans	Phone: 866-814-5506	Fax: 866-249-6155
	<b>Non-Specialty Medications</b>		
	MassHealth	Phone: 877-433-7643	Fax: 866-255-7569
	Commercial	Phone: 800-294-5979	Fax: 888-836-0730
	Exchange	Phone: 855-582-2022	Fax: 855-245-2134
	<b>Medical Specialty Medications (NLX)</b>		
	All Plans	Phone: 844-345-2803	Fax: 844-851-0882
<b>Exceptions</b>	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**

	FIRST-LINE	SECOND-LINE
<b>Medications for Acne Vulgaris</b>	<p><b>Topical Anti-infectives:</b> OTC benzoyl peroxide Generic benzoyl peroxide (various formulations) Generic clindamycin 1% Generic erythromycin 2% Generic sulfacetamide 10% &amp; sulfur 5% Generic sulfacetamide 10%</p> <p><b>**Topical Retinoids:</b> Generic tretinoin cream (0.05% &amp; 0.1%) Generic tretinoin gel (0.01%, 0.025% &amp; 0.1%)</p>	<p><b>Topical Anti-infectives:</b> Azelex (azelaic acid) 20% cream Aczone (dapsone) 7.5% gel Dapsone 5% gel</p> <p><b>Topical Retinoids:</b> Atralin (tretinoin) 0.05% gel adapalene 0.3% gel (RX) adapalene 0.1% cream (RX) Differin (adapalene) 0.1% lotion Tazarotene 0.1% cream Tazorac (tazarotene) 0.05% cream</p>

	FIRST-LINE	SECOND-LINE
	Differin OTC (adapalene) 0.1% Gel	Tazorac (tazarotene) 0.05% & 0.1% gel tretinoin microsphere 0.04%, 0.1% gel Fabior (tazarotene) 0.1% aerosol foam
<b>Medications for Acne Rosacea</b>	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:

**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, 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%, 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**

1. Benzoyl peroxide) [prescribing information]. Scottsdale, AZ: ProGen Inc.; received February 2017.
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
4. Ovace Plus (sulfacetamide) foam [prescribing information]. San Antonio, TX: Mission Pharmacal Co; January 2015.
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 (dapson) [prescribing information]. Irvine, CA: Allergan; May 2018.:
9. Avita (tretinoin) gel [prescribing information]. Morgantown, WV: Mylan Pharmaceuticals; January 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.
12. Tazorac cream (tazarotene) [prescribing information]. Irvine, CA: Allergan, Inc; July 2017
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.
16. Metronidazole gel [prescribing information]. Bridgewater, NJ: Valeant; March 2014
17. Noritate (metronidazole) 1% cream [prescribing information]. Bridgewater, NJ: Valeant; March 2018.
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.
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.
21. 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.
22. 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.

### 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)  
01/20/2021 – Reviewed and Updated. Separated out Comm/Exch vs. MH criteria. Effective 02/01/21.

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