Pharmacy Drug Policy Checklist

POLICY NAME	Brimonidine Tartrate Gel	POLICY #	2069P

Criteria

Coverage Criteria

- ☐ **1.1** Diagnosis of rosacea
- ☐ **1.2** Documented failure, intolerance, or contraindication to topical (applied to the skin) metronidazole
- ☐ **1.3** Documented failure, intolerance, or contraindication to oral (taken by mouth) doxycycline