

POLICY NAME	Brimonidine Tartrate Gel	POLICY #	2069P
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Criteria

Coverage Criteria

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