

POLICY NAME	Rhofade (oxymetazoline)	POLICY #	2600P
--------------------	-------------------------	-----------------	--------------

Criteria

Coverage Criteria

- ☐ 1.1 Diagnosis of rosacea
- ☐ 1.2 Ordered by a dermatologist (skin doctor)
 - Initial request only
- ☐ 1.3 Documented failure, intolerance, or contraindication to topical metronidazole
- ☐ 1.4 Documented failure, intolerance, or contraindication to oral doxycycline