Policy Name:	Rhofade (oxymetazoline)	Policy#:	2600P

Purpose of the Policy

The purpose of this policy is to define coverage criteria for Rhofade (oxymetazoline).

Statement of the Policy

Health Alliance Medical Plans will approve the use of Rhofade (oxymetazoline) if the following criteria are met.

Criteria

1. 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

2. Managed Dose Limit
2.1   All dermatological products have a Managed Dose Limit (MDL) in place allowing only the smallest package size of each product to process
2.2   Requests for larger package sizes will require documentation of medical necessity, including the following:
- At least two previous paid claims for the product in the smallest package size within the previous month

3. Approval Period
3.1   Initial Approval: 12 months
3.2   Reapproval: 12 months

CPT Codes

HCPCS Codes

References

1. Rhofade (oxymetazoline) [prescribing information]. Raleigh, NC: Mayne Pharma; October 2023.
2. Del Rosso JQ, Tanghetti E, Webster G, et al. Update on the Management of Rosacea from the American Acne & Rosacea Society (AARS). J Clin Aesthet Dermatol. 2019 Jun;12(6):17-24.
3. Thiboutot D, Anderson R, Cook-Bolden F, et al. Standard management options for rosacea: the 2019 update by the National Rosacea Society Expert Committee. J Am Acad Dermatol 2020;82(6):1501–1510.

Created Date: 06/07/2017
Effective Date: 06/07/2017
Posted to Website: 01/01/2022
Revision Date: 04/02/2025