**Dermatological: Topical Acne Products**

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| Criteria 1 | NP- Amzeeq, Azelaic Acid Gel, Benzoyl Peroxide Foam, Clindacin Kit, Clindamycin Foam, Clindamycin Swabs, Dapsone Gel, Epsolay, Finacea Foam, Onexton Gel, Ovace Plus, Sodium Sulfacetamide/Sulfur Gel, Sodium Sulfacetamide Pads, Winlevi |
| Criteria 2 | NP Agents- Topical Retinoids (all have AR)- Adapalene Cream, Adapalene Sol 0.1%, Adapalene Gel 0.3%, Adapalene/Benzoyl Peroxide, Aklief, Altreno, Arazlo, Clindamycin/Tretinoin, Plixda, Tazarotene Foam 0.1%, Tazarotene Gel 0.1% |
| Criteria 3 | NP Criteria- Twyneo (NP, AR) |
| Criteria 4 | NP Criteria - Tazarotene Cream (NP, AR) |
| Criteria 5 | Topical Retinoids- Adapalene Gel 0.1% (P, AR), Tretinoin (P, AR) |

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| **Criteria Title** | Dermatologic Agents: Topical Acne Products | | |
| **Criteria Subtitle** | Non-Preferred Products: Non-Retinoids | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| AMZEEQ | 080360 | GCNSeqNo |
| AZELAIC ACID GEL | 051812 | GCNSeqNo |
| BENZOYL PEROXIDE FOAM | 065589 | GCNSeqNo |
| BENZOYL PEROXIDE FOAM | 066879 | GCNSeqNo |
| BENZOYL PEROXIDE FOAM | 080592 | GCNSeqNo |
| CLINDACIN KIT | 067124 | GCNSeqNo |
| CLINDAMYCIN FOAM, SWABS | 058418 | GCNSeqNo |
| CLINDAMYCIN FOAM, SWABS | 022140 | GCNSeqNo |
| DAPSONE GEL | 061136 | GCNSeqNo |
| DAPSONE GEL | 075635 | GCNSeqNo |
| EPSOLAY | 083337 | GCNSeqNo |
| FINACEA FOAM | 074590 | GCNSeqNo |
| ONEXTON GEL | 073195 | GCNSeqNo |
| OVACE PLUS | 053380 | GCNSeqNo |
| OVACE PLUS | 063084 | GCNSeqNo |
| OVACE PLUS | 065889 | GCNSeqNo |
| OVACE PLUS | 072502 | GCNSeqNo |
| OVACE PLUS | 073027 | GCNSeqNo |
| SODIUM SULFACETAMIDE/SULFUR GEL | 073027 | GCNSeqNo |
| SODIUM SULFACETAMIDE PADS | 057943 | GCNSeqNo |
| SODIUM SULFACETAMIDE PADS | 064589 | GCNSeqNo |
| WINLEVI | 081428 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0998 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 0999 |
| Continuation (re-authorization request) | 1234 |
| 2 | 0999 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1000 |
| N | 1235 |
| 3 | 1000 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 30 days of at least three preferred drugs?  If yes, please submit the medication trials and dates. | Y | 1002 |
| N | 1001 |
| 4 | 1001 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | 1002 |
| N | 1236 |
| 5 | 1002 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 1003 |
| N | END (Pending Manual Review) |
| 6 | 1003 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | END (Pending Manual Review) |
| N | 1235 |
| 7 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | END (Pending Manual Review) |
| N | 1235 |
| 8 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 9 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 Days

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| **Last Approved** | 4/24/2023 |
| **Other** |  |

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| **Criteria Title** | Dermatologic Agents: Topical Acne Products | | |
| **Criteria Subtitle** | Non-Preferred Products: Retinoids | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| ADAPALENE CREAM, SOL 0.1% | 031789 | GCNSeqNo |
| ADAPALENE CREAM, SOL 0.1% | 066179 | GCNSeqNo |
| ADAPALENE GEL 0.3% | 062811 | GCNSeqNo |
| ADAPALENE GEL 0.3% | 068878 | GCNSeqNo |
| ADAPALENE/BENZOYL PEROXIDE | 068880 | GCNSeqNo |
| ADAPALENE/BENZOYL PEROXIDE | 074495 | GCNSeqNo |
| AKLIEF | 080265 | GCNSeqNo |
| ALTRENO | 078800 | GCNSeqNo |
| ARAZLO | 080595 | GCNSeqNo |
| CLINDAMYCIN/TRETINOIN | 061775 | GCNSeqNo |
| PLIXDA | 045146 | GCNSeqNo |
| TAZAROTENE FOAM 0.1% | 069204 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0997 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 0998 |
| Continuation (re-authorization request) | 1234 |
| 2 | 0998 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 0999 |
| N | 1235 |
| 3 | 0999 |  | Select | Does the patient have a diagnosis of skin cancer? | Y | END (Approve x 365 days) |
| N | 1000 |
| 4 | 1000 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 90 days of at least three preferred drugs?  If yes, please submit the medication trials and dates. | Y | 1002 |
| N | 1001 |
| 5 | 1001 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | 1002 |
| N | 1236 |
| 6 | 1002 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 1003 |
| N | 1004 |
| 7 | 1003 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | 1004 |
| N | 1235 |
| 8 | 1004 |  | Select | Is the patient 24 years of age and older? | Y | 1235 |
| N | END (Pending Manual Review) |
| 9 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | END (Pending Manual Review) |
| N | 1235 |
| 10 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 11 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 Days

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| **Last Approved** | 4/24/2023 |
| **Other** | If 24 or older, must meet criteria and have a diagnosis of acne or skin cancer |

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| **Criteria Title** | Dermatologic Agents: Topical Acne Products | | |
| **Criteria Subtitle** | Twyneo | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| TWYNEO | 082535 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0997 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 0998 |
| Continuation (re-authorization request) | 1234 |
| 2 | 0998 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 0999 |
| N | 1235 |
| 3 | 0999 |  | Select | Does the patient have a diagnosis of skin cancer? | Y | END (Pending Manual Review) |
| N | 1000 |
| 4 | 1000 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 90 days of at least three preferred drugs?  If yes, please submit the medication trials and dates. | Y | 1002 |
| N | 1001 |
| 5 | 1001 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | 1002 |
| N | 1236 |
| 6 | 1002 |  | Select and Free Text | Has the provider submitted documentation for the patient’s inability to use the individual drugs?  If yes, please submit documentation. | Y | 1003 |
| N | 1235 |
| 7 | 1003 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 1004 |
| N | 1005 |
| 8 | 1004 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | 1005 |
| N | 1235 |
| 9 | 1005 |  | Select | Is the patient 24 years of age and older? | Y | 1235 |
| N | END (Pending Manual Review) |
| 10 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | END (Pending Manual Review) |
| N | 1235 |
| 11 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 12 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 Days

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| **Last Approved** | 4/24/2023 |
| **Other** | If 24 or older, must meet criteria and have a diagnosis of acne |

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| **Criteria Title** | Dermatologic Agents: Topical Acne Products | | |
| **Criteria Subtitle** | Tazorac 0.1% Cream | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| TAZAROTENE 0.1% CREAM | 046984 | GCNSeqNo |
| TAZAROTENE GEL 0.1% | 031601 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0996 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 0997 |
| Continuation (re-authorization request) | 1234 |
| 2 | 0997 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 0998 |
| N | 1235 |
| 3 | 0998 |  | Select | Does the patient have a diagnosis of skin cancer? | Y | END (Pending Manual Review) |
| N | 0999 |
| 4 | 0999 |  | Select | Does the patient have a diagnosis of psoriasis? | Y | END (Approve x 365 days) |
| N | 1000 |
| 5 | 1000 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 90 days of at least three preferred drugs?  If yes, please submit the medication trials and dates. | Y | 1002 |
| N | 1001 |
| 6 | 1001 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | 1002 |
| N | 1236 |
| 7 | 1002 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 1003 |
| N | 1004 |
| 8 | 1003 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | 1004 |
| N | 1235 |
| 9 | 1004 |  | Select | Is the patient 24 years of age and older? | Y | 1235 |
| N | END (Pending Manual Review) |
| 10 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | END (Pending Manual Review) |
| N | 1235 |
| 11 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 12 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 Days

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| **Last Approved** | 4/24/2023 |
| **Other** | If 24 or older, must meet criteria and have a diagnosis of acne |

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| **Criteria Title** | Dermatologic Agents: Topical Acne Products | | |
| **Criteria Subtitle** | Preferred Products: Retinoids | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred | X | | Non-Preferred |  | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| ADAPALENE GEL 0.1% | 026436 | GCNSeqNo |
| TRETINOIN | 005797 | GCNSeqNo |
| TRETINOIN | 005798 | GCNSeqNo |
| TRETINOIN | 005799 | GCNSeqNo |
| TRETINOIN | 005800 | GCNSeqNo |
| TRETINOIN | 005801 | GCNSeqNo |
| TRETINOIN | 021108 | GCNSeqNo |
| TRETINOIN | 030614 | GCNSeqNo |
| TRETINOIN | 050417 | GCNSeqNo |
| TRETINOIN | 068881 | GCNSeqNo |
| TRETINOIN | 068882 | GCNSeqNo |
| TRETINOIN | 072395 | GCNSeqNo |
| TRETINOIN | 077907 | GCNSeqNo |
| TRETINOIN | 046783 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 1234 |  | Select | Is the patient 24 years and older?  Please note: a PA is only required for patients 24 years and older. | Y | 1235 |
| N | 1236 |
| 2 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 3 | 1236 |  | Free Text | A PA is not required for those younger than 24 years of age. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 Days

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| **Last Approved** | 4/24/2023 |
| **Other** | If 24 or older, must meet criteria and have a diagnosis of acne or skin cancer |