

Market Applicability/Effective Date														
Market	FL & FHK	FL MMA	FL LTC	GA	KS	KY	LA	MD	NJ	NV	NY	TN	TX	WA
Applicable	X	N/A	N/A	X	N/A	X	X	X	X	X	X	N/A	N/A	X

\*FHK- Florida Healthy Kids

## Tazarotene Agents

Override(s)	Approval Duration
Prior Authorization Quantity Limit	1 year

Medications	Quantity Limit
Avage (tazarotene) Fabior (tazarotene) Tazorac (tazarotene)	May be subject to quantity limit

### APPROVAL CRITERIA

If benefit requires prior authorization, requests for tazarotene agents (Tazorac, Fabior) may be approved for the following:

I. For Tazorac (tazarotene) cream/gel 0.1%:

- A. Individual has a diagnosis of mild-to-moderate facial acne; **AND**
- B. Individual has had a prior trial (medication samples/coupons/discount cards are excluded from consideration as a trial) and inadequate response to one preferred generic topical tretinoin agent; **AND**
- C. Documentation\* is provided for the clinical necessity of a non-preferred agent and the same medical reason and clinical benefit are not expected with the preferred agent;

Preferred generic agents: Tretinoin gel 0.01%, 0.025%; tretinoin gel micro 0.1%; tretinoin cream 0.025%, 0.05%, 0.1%.

All pump formulations of tretinoin are non-preferred.

**OR**

II. For Tazorac (tazarotene) cream/gel 0.05% and cream/gel 0.1%:

- A. Individual has a diagnosis of stable plaque psoriasis; **AND**
- B. Individual has up to 20% of body surface area involvement; **AND**
- C. Efficacy must be documented\* for continued approval if request is for greater than 1 year of treatment; **AND**
- D. Individual has had a prior trial of either of the following (AAD 2009):
  - 1. Any two topical corticosteroids; **OR**
  - 2. Any one topical corticosteroid plus calcipotriene;

**OR**

III. For Fabior (tazarotene) aerosol foam:

- A. Individual has a diagnosis of moderate-to-severe acne; **AND**

This policy does not apply to health plans or member categories that do not have pharmacy benefits, nor does it apply to Medicare. Note that market specific restrictions or transition-of-care benefit limitations may apply.

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- B. Individual has had a prior trial (medication samples/coupons/discount cards are excluded from consideration as a trial) and inadequate response to one preferred generic topical tretinoin agent; **AND**.
- C. Documentation\* is provided for the clinical necessity of a non-preferred agent and the same medical reason and clinical benefit are not expected with the preferred agent.

Preferred generic agents: Tretinoin gel 0.01%, 0.025%; tretinoin gel micro 0.1%; tretinoin cream 0.025%, 0.05%, 0.1%.

All pump formulations of tretinoin are non-preferred.

\*Documentation includes, but is not limited to, chart notes, prescription claims records, prescription receipts.

Tazarotene agents (Avage, Fabior, and Tazorac) may not be approved for cosmetic purposes such as, but not limited to the following:

- I. Photoaging; **OR**
- II. Wrinkles; **OR**
- III. Hyperpigmentation; **OR**
- IV. Sun damage; **OR**
- V. Melasma.

Avage (tazarotene) may not be approved for the following:

- I. Acne; **OR**
- II. Plaque Psoriasis.

VI. State Specific Mandates		
State name	Date effective	Mandate details (including specific bill if applicable)
N/A	N/A	N/A

**Key References:**

Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.: 2016. URL: <http://www.clinicalpharmacology.com>. Updated periodically.

DailyMed. Package inserts. U.S. National Library of Medicine, National Institutes of Health website. <http://dailymed.nlm.nih.gov/dailymed/about.cfm>.

DrugPoints® System (electronic version). Truven Health Analytics, Greenwood Village, CO. Updated periodically.

Lexi-Comp ONLINE™ with AHFS™, Hudson, Ohio: Lexi-Comp, Inc.; 2016; Updated periodically.

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