# RAdvance

Clinical Policy Title:	oxymetazoline hydrochloride
Policy Number:	RxA.267
Drug(s) Applied:	Rhofade®
Original Policy Date:	02/07/2020
Last Review Date:	8/28/2024
Line of Business Policy Applies to:	All lines of business (except Medicare)

## Criteria

## I. Initial Approval Criteria

- A. Facial Erythema Associated with Rosacea (must meet all):
  - 1. Diagnosis of persistent facial erythema associated with rosacea;
  - 2. If papules or pustules are present, a failure of or concomitant treatment with any of the following agents, unless contraindicated or clinically significant adverse effects are experienced: topical metronidazole, oral doxycycline, ivermectin cream or azelaic acid.

#### **Approval Duration**

All Lines of Business (except Medicare): 12 months

### II. Continued Therapy Approval

- A. Facial Erythema Associated with Rosacea (must meet all):
  - 1. Auto-approval based on lookback functionality within the past 120 days as a proxy for member responding positively to therapy.

### **Approval Duration**

### All Lines of Business (except Medicare): 12 months

#### References

1. National Rosacea Society. Rosacea treatment algorithms. Available at: <u>https://www.rosacea.org/physicians/treatmentalgorithms.</u> Accessed August 28, 2024.

Review/Revision History	Review/Revision Date	P&T Approval Date
Policy established.	01/2020	02/07/2020
<ol> <li>Policy was reviewed:</li> <li>Clinical Policy Title was updated.</li> <li>Drug(s) Applied was updated.</li> <li>Line of Business Policy Applies to was updated.</li> <li>Continued Therapy criteria II.A.1 was rephrased to "Currently receiving medication that has been authorized</li> </ol>	07/13/2020	09/14/2020
by RxAdvance" 5. Commercial approval duration and		

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<ul> <li>Medicaid approval duration updated.</li> <li>6. References were updated.</li> <li>7. Reworded dosing regimen to: "Apply a pea-size amount once daily in a thin layer to cover the entire face (forehead, chin, nose, and each cheek) avoiding the eyes and lips."</li> <li>8. Updated Initial Approval Criteria #3 – removed Finacea and added azelaic acid.</li> </ul>		
<ol> <li>Policy was reviewed:</li> <li>Clinical Policy Title was updated.</li> <li>Continued therapy criteria II.A.1 was rephrased to "Member is currently receiving medication that has been authorized by RxAdvance"</li> <li>References were reviewed and updated.</li> </ol>	04/12/2021	06/10/2021
<ul><li>Policy was reviewed:</li><li>1. References were reviewed and updated.</li></ul>	01/25/2022	04/18/2022
<ul> <li>Policy was reviewed:</li> <li>1. Initial Approval Criteria I.A.4:Updated to add ivermectin cream as an option for failure.</li> <li>2. References were reviewed and updated.</li> </ul>	12/30/2022	04/13/2023
Policy was reviewed.	10/19/2023	10/19/2023
<ol> <li>Policy was reviewed:         <ol> <li>Removed age restrictions.</li> <li>Removed dose restrictions.</li> <li>Updated Continued therapy approval with auto-approval based on lookback functionality within the past 120 days.</li> <li>Removed reauthorization requirement for positive response to therapy.</li> <li>Updated approval duration verbiage.</li> <li>References were reviewed and</li> </ol> </li> </ol>	8/28/2024	9/13/2024