Clinical Policy Title:	tazarotene
Policy Number:	RxA.627
Drug(s) Applied:	Arazlo®
Original Policy Date:	05/21/2020
Last Review Date:	12/1/2023
Line of Business Policy Applies to:	All lines of business (except Medicare)

Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria. The provision of provider samples does not guarantee coverage under the terms of the pharmacy benefit administered by RxAdvance. All criteria for initial approval must be met in order to obtain coverage.

I. Initial Approval Criteria

A. Acne Vulgaris (must meet all):

1. Diagnosis of acne vulgaris;
2. Trial and failure of one (1) of topical retinoid agent (e.g., topical adapalene, topical tretinoin, generic adapalene-benzoyl peroxide, generic tazarotene, etc.), unless contraindicated or clinically significant adverse effects are experienced;

Approval Duration

All Lines of Business (except Medicare): 12 months

II. Continued Therapy Approval

A. Acne Vulgaris (must meet all):

1. Member is currently receiving medication, excluding manufacturer samples;

Approval Duration

All Lines of Business (except Medicare): 12 months

References

1. Zaenglein AL, Pathy AL, Schlosser BJ et al. Guidelines of care for the management of acne vulgaris. J Am Acad Dermatol. 2016 May;74(5):945-73.e33. doi: 10.1016/j.jaad.2015.12.037. Available at https://www.aad.org/member/clinical-quality/guidelines/acne. Accessed October 20, 2022.
2. FDA approves ortho dermatologics Arazlo® (tazarotene) lotion, 0. 045%, for acne vulgaris. Investors release. Bausch health. December 2019. Avaliable at: https://ir.bauschhealth.com/news-releases/2019/12-19-2019-115754291. Accessed October 20, 2022.

Review/Revision History	Review/Revision Date	P&T Approval Date
Policy established.	05/04/2020	05/21/2020
Policy was reviewed: 1. Continuation therapy criteria II.A.1. rephrased to “Member is currently	01/19/2021	03/09/2021

receiving medication that has been authorized by RxAdvance or the member has met initial approval criteria listed in this policy 2. Appendix B: Therapeutic Alternatives QD, BID, TID changed to once daily, twice a day and three times a day respectively 3. Therapeutic alternative verbiage changed to "Below are suggested therapeutic alternatives based on clinical guidance. Please check drug formulary for preferred agents and utilization management requirements" 4. References were updated 5. Updated initial approval criteria based on the clinical guidelines and the availability of preferred agents within same drug class 6. Updated therapeutic alternatives table to include other topical retinoids.		
Policy was reviewed: 1. Statement about ''The provision of provider samples does not guarantee coverage…" was added to Clinical Policy. 2. II.A.1 Member is currently receiving medication that has been authorized by RxAdvance..." 3. Appendix B, Dosing Regimen, Epiduo: Updated dosing information from Not applicable to 1 application per day topically for indication acne vulgaris. 4. Appendix B, Dosing Regimen, Epiduo Forte: Updated dosing information from Not applicable to 1 application per day topically for indication acne vulgaris. 5. Appendix B, Dosing Regimen, Tazorac: Updated dosing information from Not applicable to 1 application per day topically for indication acne vulgaris. 6. Disclaimer about contraindication." Contraindications listed reflect statements made in the manufacturer's package insert.." was added to Appendix C. 7. References were reviewed and updated.	11/24/2021	1/17/2022
Policy was reviewed: 1. Initial Approval Criteria I.A.3: Updated from trial and failure of two (2) preferred topical retinoid agents to trial and failure	10/20/2022	01/17/2023

of one (1) topical retinoid agents. 2. Appendix A: Updated to remove abbreviations FDA 3. References were reviewed and updated.		
Policy was reviewed.	12/1/2023	12/1/2023