Clinical Policy Title:	tazarotene
Policy Number:	RxA.688
Drug(s) Applied:	Tazorac®
Original Policy Date:	07/30/2021
Last Review Date:	08/28/2024
Line of Business Policy Applies to:	All lines of business (except Medicare)

Criteria

I. Initial Approval Criteria

A. Plaque psoriasis (must see all):

1. Diagnosis of plaque psoriasis;
2. If request is for Tazorac Gel, body surface area involvement of plaque psoriasis is ≤ 20%.
   a. Trial and failure of at least one (1) topical corticosteroid (e.g., clobetasol, mometasone, triamcinolone) unless contraindicated or clinically significant adverse effects are experienced.

Approval Duration

All Lines of Business (except Medicare): 12 months

B. Acne vulgaris (must see all):

1. Diagnosis of acne vulgaris;
2. If request is for Tazorac® 0.1% Gel, diagnosis is mild to moderate facial acne vulgaris;
   a. Trial and failure of at least two (2) preferred retinoid agents (e.g., topical adapalene, generic adalapene-benzoyl peroxide, generic tazarotene) unless contraindicated or clinically significant adverse effects are experienced.

Approval Duration

All Lines of Business (except Medicare): 12 months

II. Continued Therapy Approval

A. All Indications in Section I (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. 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.e 33. doi: 10.1016/j.jaad.2015.12.037. Available at https://www.jaad.org/article/S0190-9622(15)02614-6/fulltext. Accessed on August 28, 2024.

Review/Revision History	Review/Revision Date	P&T Approval Date
Policy established.	07/30/2021	09/14/2021

Policy was reviewed: 1. Initial Approval Criteria, I.A.2, I.B.2: Updated to include new prescriber criteria "Prescribed by or in consultation with dermatologist". 2. Initial Approval Criteria I.A and I.B updated to remove prescriber criteria. 3. References were reviewed and updated.	04/28/2022	07/18/2022
Policy was reviewed: 1. Removed prior dosing criteria. 2. Updated approval duration. 3. Removed reauthorization requirement for positive response to therapy. 4. References were reviewed and updated.	11/21/2023	01/01/2024
Policy was reviewed: 1. Removed age restrictions. 2. Updated Continued therapy approval with auto-approval based on lookback functionality within the past 120 days. 3. Reference was reviewed and updated.	08/28/2024	9/13/2024