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

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Azelaic Acid Agents

Override(s)	Approval Duration
Prior Authorization	1 year

Medications	Quantity Limit
Azelex (azelaic acid) Finacea (azelaic acid)	May be subject to quantity limit

APPROVAL CRITERIA

If the benefit requires prior authorization, requests for azelaic acid agents (Azelex, Finacea) may be approved for the following:

I. For Azelex (azelaic acid) cream:
   A. Individual has a diagnosis of mild-to-moderate inflammatory 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**

      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.

   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; **OR**
   D. Individual is pregnant and requires a topical non-retinoid treatment; **OR**
   E. Individual has a diagnosis of mild-to-moderate inflammatory papulopustular rosacea (AHFS); **AND**
   F. 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 metronidazole agent; **OR**

      Preferred generic topical metronidazole agents: metronidazole topical 0.75% gel, metronidazole 0.75% cream, metronidazole 0.75% lotion, rosadan 0.75% gel, rosadan 0.75% cream.

   G. Individual has a known topical metronidazole contraindication; **OR**

I. For Finacea (azelaic acid) gel and foam:

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.
WEB-PEC-0565-17

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

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A. Individual has a diagnosis of mild-to-moderate inflammatory papulopustular rosacea; **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 metronidazole; **OR**

   Preferred generic topical metronidazole agents: metronidazole topical 0.75% gel, metronidazole 0.75% cream, metronidazole 0.75% lotion, rosadan 0.75% gel, rosadan 0.75% cream

C. Individual has a known topical metronidazole contraindication.

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

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.