Market Applicability							
Market	**DC**	**GA**	**KY**	**MD**	**NJ**	**NY**	**WA**
Applicable	X	X	X	X	X	X	X

Cosmetic Anti-Aging

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

Medications	Comments	Quantity Limit
tretinoin gel 0.01% and 0.025%	Preferred	May be subject to quantity limits
tretinoin gel micro 0.1%		
tretinoin cream 0.025%, 0.05%, 0.1%		
Altreno (tretinoin)	Non-Preferred	
Atralin (tretinoin)		
Avita (tretinoin)		
Refissa (tretinoin)		
Renova (tretinoin/emollient)		
Retin-A (tretinoin)		
Retin-A Micro (tretinoin)		
Tretin-X (tretinoin)		
tretinoin gel 0.05%		

All pump formulations are non-preferred

APPROVAL CRITERIA

Requests for a preferred topical tretinoin agent [tretinoin gel (0.01%, 0.025%), tretinoin gel micro (0.1%), or tretinoin cream (0.025%, 0.05%, or 0.1%)] may be approved for the following:

I. Individual has one of the following diagnoses:
   A. Acne; **OR**
   B. Rosacea; **OR**
   C. Molluscum contagiosum (only 3 weeks of treatment).

Requests for non-preferred topical tretinoin agents (Altreno, Atralin, Avita, Retin-A, Retin-A Micro, Tretin-X, tretinoin gel 0.05%) may be approved for the following:

I. Individual has one of the following diagnoses:

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.

Market Applicability							
Market	**DC**	**GA**	**KY**	**MD**	**NJ**	**NY**	**WA**
Applicable	X	X	X	X	X	X	X

A. Acne; **OR**
B. Rosacea; **OR**
C. Molluscum contagiosum (only 3 weeks of treatment);

AND

II. Individual has had a prior trial (medication samples/coupons/discount cards are excluded from consideration as a trial) and inadequate response or intolerance to two preferred single ingredient topical retinoid agents; **AND**

Preferred agents for diagnosis of **acne**: OTC Differin, tretinoin gel (0.01%, 0.025%), tretinoin gel micro (0.1%) or tretinoin cream (0.025%, 0.05%, or 0.1%)

Preferred agents for diagnosis of **rosacea or molluscum contagiosum**: tretinoin gel (0.01%, 0.025%), tretinoin gel micro (0.1%) or tretinoin cream (0.025%, 0.05%, or 0.1%)

III. The non preferred agent is being used for the same medical reason as the preferred agents and the same clinical benefit is not expected with the preferred agents.

Topical tretinoin agents (Altreno, Atralin, Avita, Refissa, Renova, Retin-A, Retin-A Micro, Tretin-X, tretinoin gel, and tretinoin cream) 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.

Refissa (tretinoin) and Renova (tretinoin) may not be approved for the following:

I. Acne; **OR**
II. Rosacea; **OR**
III. Molluscum contagiosum.

Key References:

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Market Applicability							
Market	**DC**	**GA**	**KY**	**MD**	**NJ**	**NY**	**WA**
Applicable	X	X	X	X	X	X	X

1. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.: 2019. URL: http://www.clinicalpharmacology.com. Updated periodically.
2. DailyMed. Package inserts. U.S. National Library of Medicine, National Institutes of Health website. http://dailymed.nlm.nih.gov/dailymed/about.cfm. Accessed: December 5, 2019.
3. DrugPoints® System [electronic version]. Truven Health Analytics, Greenwood Village, CO. Updated periodically.
4. Lexi-Comp ONLINE™ with AHFS™, Hudson, Ohio: Lexi-Comp, Inc.; 2019; Updated periodically.

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