PRIOR AUTHORIZATION CRITERIA

DRUG CLASS **ACNE MEDICATIONS**

BRAND NAME

ACANYA

ACZONE

AVAR

AKNE-MYCIN

AZELEX

BENZAC

BENZACLIN

BENZIQ

CLEOCIN-T

CLINDAGEL

DUAC

EPIDUO

EPIDUO FORTE

ERYGEL

EVOCLIN

INOVA EASY PAD

KLARON

ONEXTON

PLEXION

RIAX

ROSAC

©2017 CVS Caremark. All rights reserved.

This document contains confidential and proprietary information of CVS Caremark and cannot be reproduced, distributed or printed without written permission from CVS Caremark. This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Caremark.

CVS caremark™

ROSANIL

ROSULA

SUMADAN

SUMAXIN

ZACLIR

Status: Client Requested Criteria
Type: Post Step Therapy Prior Authorization ***Ref # C8908-D***

INITIAL STEP THERAPY

If the patient has filled a prescription for at least a 1 day supply of at least two of the following generic topical products: benzoyl peroxide, clindamycin, erythromycin, clindamycin/benzoyl peroxide, erythromycin/benzoyl peroxide, sodium sulfacetamide, sodium sulfacetamide/sulfur, tretinoin, or adapalene-containing products within the past 130 days under a prescription benefit administered by CVS Caremark, then the requested drug will be paid under that prescription benefit. If the patient does not meet the initial step therapy criteria, then the claim will reject with a message indicating that a prior authorization (PA) is required. The prior authorization criteria would then be applied to requests submitted for evaluation to the PA unit.

CRITERIA FOR APPROVAL

1	Has the patient had a trial and failure of any TWO of the following generic topical products: A) benzoyl peroxide, B) clindamycin, C) erythromycin, D) clindamycin/benzoyl peroxide, E) erythromycin/benzoyl peroxide, F) sodium sulfacetamide, G) sodium sulfacetamide/sulfur, H) tretinoin product or I) adapalene-containing products?	Yes	No

Mapping Instructions		
	Yes	**No**
1.	Approve, 12 months	Deny

REFERENCES

1. NCSHP Prior Authorization Approval Policy.

Written by: UM Development (NB)
Date Written: 05/2016
Revised: (ME) 09/2017
Reviewed: Medical Affairs: (LS) 05/2016, (JG) 09/2017

The Participating Group signed below hereby accepts and adopts as its own the criteria for use with Prior Authorization, as administered by CVS Caremark.

_____ _____
Signature Date

_____
Client Name

©2017 CVS Caremark. All rights reserved.

This document contains confidential and proprietary information of CVS Caremark and cannot be reproduced, distributed or printed without written permission from CVS Caremark. This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Caremark.