Commercial/Healthcare Exchange PA Criteria

Effective: July 25th, 2018

Prior Authorization: Rosacea Topicals

Products Affected: Noritate 1% cream, Rhofade 1% cream, Finacea 15% foam/gel, Soolantra 1 % cream, Ivermectin topical 1% cream, Mirvaso 0.33% gel, Brimonidine gel pump

Covered Uses: Treatment of rosacea

Required Medical Information: Chart notes, pharmacy claims

Coverage Duration: Up to 12 months

Other Criteria: Connecticare considers **Noritate, Rhofade, Finacea, Ivermectin, Soolantra,** and **Mirvaso** to be medically necessary for patients who meet the following criteria:

1. Patient has clinically diagnosed rosacea
2. Patient has had an intolerance to, or treatment failure of one of the following:
    a. Metronidazole 0.75 % cream
    b. Metronidazole 0.75 % gel
    c. Metronidazole 1 % gel

References:

1. Rhofade full prescribing information, Allergan, Irvine CA
2. Noritate (metronidazole) 1% cream full prescribing information, Bridgewater, NJ: Valeant.
3. Mirvaso full prescribing information, Galderma Laboratories, L.P., Fort Worth, TX
4. Soolantra full prescribing information, Galderma Laboratories, L.P., Fort Worth, TX
5. Finacea full prescribing information, Bayer HealthCare Pharmaceuticals Inc., Whippany, NJ
6. Facts & Comparisons Online

Policy Revision history

Rev #	Type of Change	Summary of Change	Sections Affected	Date
1.	Revision	New Policy	All	7/18
2	Update	Added Ivermectin topical 1% cream to policy (generic Soolantra)	Products affected	10/28/19

3	Update	Added Brimonidine to Products Affected	Products Affected	2/2/2023