

Clinical Policy: Topical Acne Treatment

Reference Number: HIM.PA.71

Effective Date: 12/14

Last Review Date: 08/17

Line of Business: Health Insurance Marketplace

[Coding Implications](#)
[Revision Log](#)

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

The following are topical acne treatment agents requiring prior authorization: adapalene cream/gel/lotion (Differin®), adapalene and benzoyl peroxide (Epiduo®), azelaic acid (Azelex®), clindamycin phosphate and benzoyl peroxide (Benzaclen®, Duac®), erythromycin and benzoyl peroxide (Benzamycin®), adapalene and clindamycin phosphate (Clindap-T® Cream, Triseon®), tretinoin microsphere gel (Retin-A Micro® 0.1%), clindamycin phosphate and tretinoin (Veltin®, Ziana®).

FDA approved indication

Topical acne agents are indicated for the treatment of acne vulgaris.

Policy/Criteria

Provider must submit documentation (including office chart notes and lab results) supporting that member has met all approval criteria

I. Initial Approval Criteria**A. Acne Vulgaris (must meet all):**

1. Diagnosis of acne vulgaris;
2. Failure of two of the following topical preparations from different classes, each trialed for ≥ 2 months, unless all are contraindicated or clinically significant adverse effects are experienced;
 - a. Topical antibiotics: clindamycin, erythromycin;
 - b. Topical anti-infectives: benzoyl peroxide;
 - c. Topical retinoids: tretinoin (cream 0.025%, 0.05%, 0.1%; gel 0.01%, 0.025%).

Approval duration: 12 months

B. Other diagnoses/indications

1. Refer to HIM.PHAR.21 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy**A. Acne Vulgaris (must meet all):**

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Documentation of positive response to therapy.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2):

CLINICAL POLICY

Topical Acne Treatment

1. Currently receiving medication via health plan benefit and documentation supports positive response to therapy.

Approval duration: Duration of request or 12 months (whichever is less); or

2. Refer to HIM.PA.21 if diagnosis is NOT specifically listed under section III
(Diagnoses/Indications for which coverage is NOT authorized)

III. Diagnoses/Indications for which coverage is NOT authorized:

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – HIM.PHAR.21 or evidence of coverage documents

IV. Appendices/General Information

Appendix A: Abbreviation Key

FDA: Food and Drug Administration

V. References

1. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2017.
Available at: <http://clinicalpharmacology-ip.com/default.aspx>.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Reformatted guideline to new format. Adjusted criteria for flow. Added Workflow reference document. Added tretinoin microsphere to this guideline.	12/15	12/15
Removed general description of different acne agent as this applies to agents that are covered without PA. Replaced the description section to indicate the policy is applicable to formulary topical acne agent requiring PA. Added requirement for diagnosis. Updated continuation criteria. Removed workflow document. Updated references to reflect current literature search.	08/16	11/16
Converted to new template.	04/17	08/17

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health

CLINICAL POLICY

Topical Acne Treatment

plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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Topical Acne Treatment

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