

<b>Policy Name:</b>	<b>Tazorac (tazarotene)</b>	<b>Policy#:</b>	<b>1899P</b>
---------------------	-----------------------------	-----------------	--------------

## Purpose of the Policy

The purpose of this policy is to define coverage criteria for Tazorac (tazarotene)

## Statement of the Policy

Health Alliance Medical Plans and Health Alliance Northwest will approve the use of Tazorac (tazarotene) under the pharmacy benefit if the following criteria are met.

## Criteria

### 1. Coverage Criteria for Acne

- 1.1 Documented diagnosis of acne vulgaris
- 1.2 Documented trial and failure of at least two formulary generic agents (e.g., topical agents such as tretinoin, adapalene, or oral tetracyclines) or documented contraindication to all topical agent and oral tetracyclines

### 2. Coverage Criteria for Plaque Psoriasis

- 2.1 Documented diagnosis of plaque psoriasis
- 2.2 Documented trial and failure of two topical formulary generic agents (e.g., corticosteroids, retinoids) required

### 3. Managed Dose Limit

- 3.1 All skin products have a Managed Dose Limit (MDL) in place allowing only the smallest package size of each product to process
- 3.2 Requests for larger package sizes will require documentation of medical necessity, including the following:
  - At least two previous paid claims for the product in the smallest package size within the previous month

### 4. Approval Period

- 4.1 12 months

## CPT Codes

## HCPCS Codes

## References

1. Tazorac (tazarotene) [prescribing information]. Exton, PA: Almirall, LLC; August 2019.
2. Elmets CA, Korman NJ, Prater EF, et al. Joint AAD-NPF Guidelines of care for the management and

treatment of psoriasis with topical therapy and alternative medicine modalities for psoriasis severity measures. Journal of the American Academy of Dermatology. Clinical Practice Guideline. 2020 July 29.

3. Zaenglein AL, Pathy AL, Schlosser BJ, et al. Guidelines of care for the management of acne vulgaris. J Am Acad Dermatol. 2016;74(5):945-973.

**Created Date:** 06/06/2012

**Effective Date:** 06/06/2012

**Posted to Website:** 01/01/2022

**Revision Date:** 04/03/2024

#### DISCLAIMER

This Medical Policy has been developed as a guide for determining medical necessity. The process of medical necessity review also entails review of the most recent literature and physician review. Medical Policy is not intended to dictate to providers how to practice medicine. Providers are expected to exercise their medical judgment in providing the most appropriate care. Health Alliance encourages input from providers when developing and implementing medical policies. Benefit determinations are based on applicable contract language in the member's Policy/ Subscription Certificate/ Summary Plan Description. This Medical Policy does not guarantee coverage. There may be a delay between the revision of this policy and the posting on the web. Please contact the Health Alliance Customer Service Department at 1-800-851-3379 for verification of coverage.