

Clinical Policy Title:	tazarotene
Policy Number:	RxA.688
Drug(s) Applied:	Tazorac®
Original Policy Date:	07/30/2021
Last Review Date:	01/01/2024
Line of Business Policy Applies to:	All lines of business (except Medicare)

Criteria

I. Initial Approval Criteria

A. Plaque psoriasis (must see all):

1. Diagnosis of plaque psoriasis;
2. Request meets one of the following (i or ii):
 - i. If request is for Tazorac® Cream:
 - a. Age ≥ 18 years;
 - ii. If request is for Tazorac® Gel, request meets (a or b):
 - a. Body surface area involvement of plaque psoriasis is ≤ 20%;
 - b. Age ≥ 12 years;
3. Trial and failure of at least one (1) topical corticosteroid (e.g., clobetasol, mometasone, triamcinolone) unless contraindicated or clinically significant adverse effects are experienced;

Approval Duration

All Lines of Business (except Medicare): 12 months

B. Acne vulgaris (must see all):

1. Diagnosis of acne vulgaris;
2. Request is for Tazorac® 0.1% and meets one of the following (i or ii):
 - i. If request is for Tazorac® Cream:
 - a. Age ≥ 12 years;
 - ii. If request is for Tazorac® Gel, request meets (a and b):
 - a. Age ≥ 12 years;
 - b. Mild to moderate facial acne vulgaris;
3. Trial and failure of at least two (2) preferred retinoid agents (e.g., topical adapalene, generic adapalene-benzoyl peroxide, generic tazarotene, etc.) unless contraindicated or clinically significant adverse effects are experienced;

Approval Duration

All Lines of Business (except Medicare): 12 months

II. Continued Therapy Approval

A. All Indications in Section I (must meet all):

1. Member is currently receiving medication, excluding manufacturer samples;

Approval Duration

All Lines of Business (except Medicare): 12 months

This clinical policy has been developed to authorize, modify, or determine coverage for individuals with similar conditions. Specific care and treatment may vary depending on individual need and benefits covered by the plan. This policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. This document may contain prescription brand name drugs that are trademarks of pharmaceutical manufacturers that are not affiliated with RxAdvance.

References

1. Zaenglein AL, Pathy AL, Schlosser BJ et al. Guidelines of care for the management of acne vulgaris. J Am Acad Dermatol. 2016 May;74(5):945-73.e 33. doi: 10.1016/j.jaad.2015.12.037. Available at [https://www.jaad.org/article/S0190-9622\(15\)02614-6/fulltext](https://www.jaad.org/article/S0190-9622(15)02614-6/fulltext). Accessed on November 21, 2023.

Review/Revision History	Review/Revision Date	P&T Approval Date
Policy established.	07/30/2021	09/14/2021
Policy was reviewed: <ol style="list-style-type: none"> 1. Initial Approval Criteria, I.A.2, I.B.2: Updated to include new prescriber criteria "Prescribed by or in consultation with dermatologist". 2. Initial Approval Criteria I.A and I.B updated to remove prescriber criteria. 3. References were reviewed and updated. 	04/28/2022	07/18/2022
Policy was reviewed: <ol style="list-style-type: none"> 1. Removed prior dosing criteria. 2. Updated approval duration. 3. Removed reauthorization requirement for positive response to therapy. 4. References were reviewed and updated. 	11/21/2023	01/01/2024