

Topical Retinoids

Drug/Drug Class

Topical Retinoids

Clinical Criteria Information Included in this Document

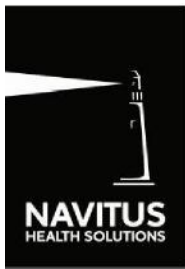
Drugs requiring prior authorization: the list of drugs requiring prior authorization for this clinical criteria

Prior authorization criteria logic: a description of how the prior authorization request will be evaluated against the clinical criteria rules

Logic diagram: a visual depiction of the clinical criteria logic

Supporting tables: a collection of information associated with the steps within the criteria (diagnosis codes, procedure codes, and therapy codes)

References: clinical publications and sources relevant to this clinical criteria

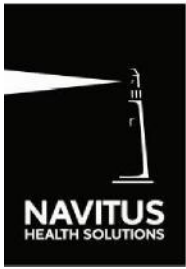


Topical Retinoids

Drugs Requiring Prior Authorization

The listed GCNS may not be an indication of TX Medicaid Formulary coverage. To learn the current formulary coverage, visit TxVendorDrug.com/formulary/formulary-search.

Drugs Requiring Prior Authorization	
Label Name	GCN
ADAPALENE 0.1% CREAM	29301
ADAPALENE 0.1% GEL	29300
ADAPALENE 0.3% GEL	98582
ADAPALENE 0.3% GEL PUMP	31773
ADAPALENE-BENZYL PEROX 0.1-2.5%	31775
AKLIEF 0.005% CREAM	46989
ALTRENO 0.5% LOTION	45194
ATRALIN 0.05% GEL	22872
AVITA 0.025% CREAM	22882
AVITA 0.025% GEL	22871
CLINDA-TRETINOIN 1.2-0.025% GEL	97560
DIFFERIN 0.1% CREAM	29301
DIFFERIN 0.1% GEL	29300
DIFFERIN 0.1% LOTION	28403
DIFFERIN 0.3% GEL PUMP	31773
EPIDUO 0.1-2.5% GEL PUMP	31775
EPIDUO FORTE 0.3-2.5% GEL PUMP	39163
FABIOR 0.1% FOAM	32178
RETIN-A MICRO PUMP 0.06% GEL	44075
TAZAROTENE 0.1% CREAM	85363
TAZORAC 0.05% CREAM	85362
TAZORAC 0.05% GEL	29221
TAZORAC 0.1% CREAM	85363
TAZORAC 0.1% GEL	29222
TRETINOIN 0.01% GEL	22870
TRETINOIN 0.025% CREAM	22882
TRETINOIN 0.025% GEL	22871
TRETINOIN 0.05% CREAM	22880
TRETINOIN 0.05% GEL	22872
TRETINOIN 0.1% CREAM	22881

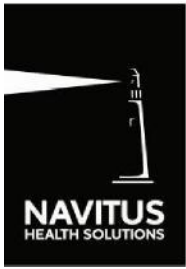


Topical Retinoids

TRETINOIN GEL MICRO 0.04% PUMP	31776
TRETINOIN GEL MICRO 0.04% TUBE	17443
TRETINOIN GEL MICRO 0.1% PUMP	31777
TRETINOIN GEL MICRO 0.1% TUBE	22874
ZIANA GEL	97560

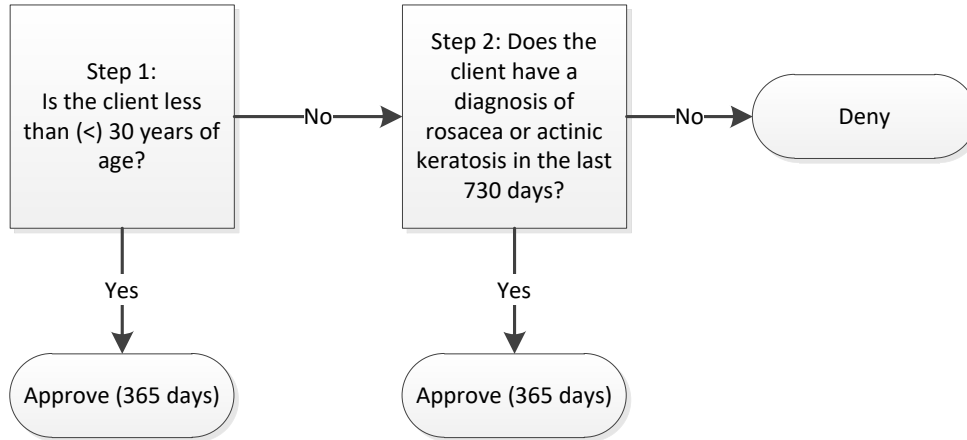
Clinical Edit Criteria Logic

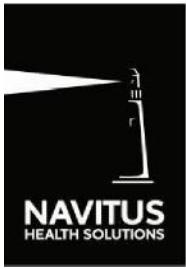
<p>1. Is the client less than (<) 30 years of age?</p> <p><input type="checkbox"/> Yes (Approve – 365 days) <input type="checkbox"/> No (Go to #2)</p>
<p>2. Does the client have a diagnosis of rosacea or actinic keratosis in the last 730 days?</p> <p><input type="checkbox"/> Yes (Approve – 365 days) <input type="checkbox"/> No (Deny)</p>



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Clinical Edit Criteria Logic Diagram

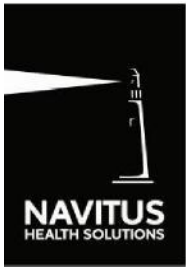




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Clinical Edit Criteria Supporting Tables

Step 2 (diagnosis of rosacea or actinic keratosis) Required quantity: 1 Look back timeframe: 730 days	
ICD-10 Code	Description
L710	PERIORAL DERMATITIS
L711	RHINOPHYMA
L718	OTHER ROSACEA
L570	ACTINIC KERATOSIS



Topical Retinoids

Clinical Edit Criteria References

1. Clinical Pharmacology [online database]. Tampa, FL: Elsevier/Gold Standard, Inc.; 2017. Available at www.clinicalpharmacology.com. Accessed on January 26, 2018.
2. Zaenglein AL, Pathy AL, Schlosser BJ, et al. Guidelines of care for the management of acne vulgaris. J Am Acad Dermatol. 2016 Feb 15.
3. Eichenfield LF, Krakowski AC, Piggot C, et al. Evidence-Based Recommendations for the Diagnosis and Treatment of Pediatric Acne. Pediatrics. 2013;131(3):163186.
4. Titus S, Hodge J. Diagnosis and Treatment of Acne. Am Fam Physician. 2012;86(8):734-740

Publication History

Publication Date	Notes
05/01/2018	Initial publication
05/10/2019	Updated to include formulary statement (The listed GCNS may not be an indication of TX Medicaid Formulary coverage. To learn the current formulary coverage, visit TxVendorDrug.com/formulary/formulary-search .) on each 'Drug Requiring PA' table
04/01/2020	Added GCN for Altreno lotion to drug table
12/01/2020	Added GCN for Akliel to drug table