Clinical Policy: Acne Agents, Topical

Reference Number: PHW.PDL.104
Effective Date: 01/01/2020
Last Review Date: 11/2025

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of PA Health & Wellness® that Topical Acne Agents are **medically necessary** when the following criteria are met:

I. Requirements for Prior Authorization of Acne Agents, Topical

A. Prescriptions That Require Prior Authorization

Prescriptions for Acne Agents, Topical that meet any of the following conditions must be prior authorized:

1. A non-preferred Acne Agent, Topical.

2. An Acne Agent, Topical that contains a topical retinoic acid derivative or azelaic acid when prescribed for a member age 21 years or older.

3. An Acne Agent, Topical with a prescribed quantity that exceeds the quantity limit.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for an Acne Agent, Topical, the determination of whether the requested prescription is medically necessary will take into account the whether the member:

1. For a non-preferred Acne Agent, Topical, has a history of therapeutic failure, contraindication, or intolerance to the preferred Acne Agents, Topical; **AND**

2. For specified preferred and non-preferred Acne Agents, Topical with active ingredient of tretinoin, adapalene, azelaic acid, or tazarotene and has a diagnosis that confirms the treatment is for a non-cosmetic indication, such as, but not limited to, acne, rosacea, or plaque psoriasis; **AND**

3. If a prescription for an Acne Agent, Topical is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth PA.CP.PMN.59 Quantity Limit Override.

NOTE: If the member does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the member, the request for prior authorization will be approved.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for an Acne Agent, Topical. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the member.

D. **Approval Duration: 12 months**

Reviews, Revisions, and Approvals	Date
Policy created	01/01/2020
Q3 2020 annual review: no changes.	07/2020
Q1 2021 annual review: no changes.	01/2021
Q3 2022 changes per DHS	08/2022
Q1 2023 annual review: no changes.	11/2022
Q1 2024 annual review: no changes.	11/2023
Q1 2025 annual review: updated language.	11/2024
Q1 2026 annual review: updated language.	11/2025