



**GEORGIA MEDICAID FEE-FOR-SERVICE  
TOPICAL ANTIACNE MEDICATIONS PA SUMMARY**

Preferred	Non-Preferred
<p>Atralin (tretinoin gel 0.05%) Avita (tretinoin cream 0.025%, tretinoin gel 0.025%) Azelex (azelaic acid cream 20%) BenzaClin Clindamycin gel, lotion, solution (1%) Duac (clindamycin 1.2%/benzoyl peroxide 5% gel) Epiduo gel (0.1% adapalene/2.5% benzoyl peroxide) Erythromycin 2% gel, solution Erythromycin-Benzoyl Peroxide (generic Benzamycin) Metrogel Tube 1% Retin-A gel (tretinoin) Tazorac (tazarotene) cream, gel Tretinoin cream 0.025%, 0.05%, 0.1% Ziana (clindamycin 1.2%/tretinoin 0.025% gel)</p>	<p>Acanya (1.2% clindamycin/2.5% benzoyl peroxide) Aczone (dapsona gel 5%, 7.5%) Adapalene 0.1% cream, lotion, 0.3% gel (generic Differin) Benzamycin Pak Clindagel 1% Clindamycin Phosphate Swab Clindamycin 1% foam Clindamycin 1%/benzoyl peroxide 5% gel (generic BenzaClin) Clindamycin 1.2%/benzoyl peroxide 5% gel (generic Duac) Clindacin PAC Kit (clindamycin phosphate swab 1% and cleanser) Differin (adapalene cream, gel, lotion) Epiduo Forte (0.3% adapalene/2.5% benzoyl peroxide) EryPads Erythromycin Swab Evoclin 1% foam (clindamycin) Fabior (tazarotene 0.1% foam) Finacea (azelaic acid aerosol/foam and gel 15%) Finanea Plus Kit (azelaic acid gel 15%, cleanser, moisturizing lotion) Metrogel Pump Metronidazole cream, gel (tube and pump), lotion Noritate (metronidazole cream 1%) Neuac Kit (clindamycin 1.2%/benzoyl peroxide 5% gel, moisturizer cream) Onexton (1.2% clindamycin/3.75% benzoyl peroxide) Retin-A Micro (tretinoin gel 0.04%, 0.1%) Retin-A Micro Pump (tretinoin gel 0.04%, 0.08%, 0.1%) Rosadan Kit (metronidazole 0.75% cream or gel, OTC skin cleanser) Soolantra (ivermectin) Tretinoin gel 0.01%, 0.025%, 0.05% Tretinoin microsphere gel 0.04%, 0.1% Tretinoin microsphere gel pump (0.04%, 0.1%) Veltin (clindamycin 1.2%/tretinoin 0.025% gel)</p>

**LENGTH OF AUTHORIZATION:** 1 Year

**NOTES:**

- ❖ Adapalene generic, Atralin, Azelex, Avita, Differin, Epiduo, Retin-A gel, Tretinoin cream, and Ziana require PA for members 21 years or older. Tazorac requires PA for members 30 years or older.
- ❖ If generic adapalene is approved, the PA will be issued for brand Differin. If brand Evoclin is approved, the PA will be issued for generic clindamycin 1% foam. If generic metronidazole 1% gel pump is approved, the PA will be issued for brand Metrogel pump.

**PA CRITERIA:**

*Atralin, Avita, Azelex, Epiduo, Retin-A Gel, Tretinoin Cream Generic, Ziana*

- ❖ Approvable for members with a diagnosis of acne vulgaris. PA is not required for members less than 21 years of age.



*Tazorac*

- ❖ Approvable for members with a diagnosis of acne vulgaris or plaque psoriasis. PA is not required for members less than 30 years of age.

*Tretinoin Gel 0.05% Generic*

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, brand Atralin, is not appropriate for the member.

*Tretinoin Gel Generic (except 0.05%), Tretinoin Microspheres Gel/Pump Generic*

- ❖ Approvable for members with a diagnosis of acne vulgaris who have tried and failed therapy with a preferred tretinoin product (Atralin, Avita, Retin-A gel or tretinoin cream) AND Azelex.

*Adapalene Generic, Differin, Epiduo Forte*

- ❖ Approvable for members with a diagnosis of acne vulgaris who have experienced ineffectiveness, allergies, contraindications, drug-drug interactions, or intolerable side effects to at least two preferred products, one of which must be Avita.

*AND*

- ❖ For generic adapalene, prescriber must submit a written letter of medical necessity stating the reasons brand Differin is not appropriate for the member.

*Veltin*

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred products, clindamycin 1% gel and tretinoin 0.025% or Ziana, are not appropriate for the member.

*Acanya, Clindamycin 1%/Benzoyl Peroxide 5% Generic, Onexton*

- ❖ Approvable for members with a diagnosis of acne vulgaris who have failed therapy with two preferred topical antibiotic products for acne, one of which must be Duac.

*AND*

- ❖ For generic clindamycin 1%/benzoyl peroxide 5%, prescriber must submit a written letter of medical necessity stating the reasons the preferred product, brand BenzaClin, is not appropriate for the member.

*Aczone*

- ❖ Approvable for members with a diagnosis of acne vulgaris who have failed therapy with two preferred topical antibiotic products for acne.

*Clindagel, Clindamycin Phosphate Swab*

- ❖ Approvable for members with a diagnosis of acne vulgaris who have failed therapy with two preferred topical antibiotic products for acne, one of which must be clindamycin.

*Ery Pads, Erythromycin Swabs*

- ❖ Approvable for members with a diagnosis of acne vulgaris who have failed therapy with two preferred topical antibiotic products for acne, one of which must be erythromycin gel or solution.

*Finacea, Finacea Plus Kit*

- ❖ Approvable for members with a diagnosis of acne rosacea who have experienced ineffectiveness, allergies, contraindications, drug-drug interactions, or intolerable side effects to the preferred product, Metrogel.

*AND*

- ❖ For Finacea Plus Kit, prescriber must submit a written letter of medical necessity stating the reasons Finacea is not appropriate for the member.



*Metrogel Pump, Metronidazole Cream/Gel/Lotion Generic, Noritate, Rosadan Kit*

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, brand Metrogel 1% tube, is not appropriate for the member.

*Benzamycin Pak*

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, generic erythromycin/benzoyl peroxide gel, is not appropriate for the member.

*Clindamycin 1.2%/Benzoyl Peroxide 5% Generic, Neuac Kit*

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, Duac, is not appropriate for the member.

*Fabior*

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, Tazorac, is not appropriate for the member.

*Clindacin PAC Kit, Clindamycin 1% Foam Generic, Evoclin*

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred products, clindamycin 1% gel, lotion, and solution, are not appropriate for the member.

*Retin-A Micro Gel, Retin-A Micro Pump, Tretinoin Micro Pump Generic*

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons generic tretinoin micro gel in tube (not pump) is not appropriate for the member.

**EXCEPTIONS:**

- ❖ Exceptions to these conditions of coverage are considered through the prior authorization process.
- ❖ The Prior Authorization process may be initiated by calling **OptumRx at 1-866-525-5827**.

**PREFERRED DRUG LIST:**

- ❖ For online access to the Preferred Drug List (PDL), please go to <http://dch.georgia.gov/preferred-drug-lists>.

**PA and APPEAL PROCESS:**

- ❖ For online access to the PA process, please go to [www.dch.georgia.gov/prior-authorization-process-and-criteria](http://www.dch.georgia.gov/prior-authorization-process-and-criteria) and click on Prior Authorization (PA) Request Process Guide.

**QUANTITY LEVEL LIMITATIONS:**

- ❖ For online access to the current Quantity Level Limits (QLL), please go to [www.mmis.georgia.gov/portal](http://www.mmis.georgia.gov/portal), highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services and select that manual.