Clinical Policy: Acne Medications

Reference Number: OR.CP.PMN.1012
Effective Date: 07.01.22
Last Review Date: 06.25
Line of Business: Medicaid – Oregon Health Plan

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
The following agents are indicated for the treatment of acne and require prior authorization: adapalene (Differin, Plixda), adapalene-benzoyl peroxide (Epiduo, Epiduo Fote), azelaic acid (Azelex, Finacea, Finevin), benzoyl peroxide (Benzac), clindamycin phosphate (Cleocin, Clindacin), clindamycin phosphate-benzoyl peroxide (Acanya, Benzaclin, Onexton), clindamycin phosphate-tretinoin (Veltin, Ziana), dapsone (Aczone), doxycycline Hyclate (Acticlate, Doryx), doxycycline monohydrate (Oracea), erythromycin, erythromycin-benzoyl peroxide (Aktipak, Benzamycin), isotretinoin (Absorica, Absorica LD, Claravis, Myorisan, Zenatane, Amnesteem), minocycline ER (Solodyn, Ximino, Minolira), minocycline microspheres (Arestin), minocycline foam (Zilxi), sulfacetamide sodium (Klaron), tazarotene (Arazlo, Fabior), tretinoin (Atralin, Avita, Retin-A), tretinoin microspheres (Retin-A Micro), trifarotene (Aklief).

Preferred Options:
- Adapalene 0.1% cream; 0.1% lotion; 0.3% gel
- Adapalene-Benzoyl Peroxide 0.1-2.5% & 0.3-2.5% gel
- Azelaic Acid 15% gel
- Benzoyl Peroxide 2.5%, 3.5%, 4%, 5%, 6%, 7% & 10% liquid; 2.5% & 10% cream; 5.3% & 9.8% foam; 2.5%, 5%, 8% & 10% gel; 5%, 8% & 10% lotion
- Benzoyl Peroxide-Erythromycin 5-3% gel
- Clindamycin Phosphate 1% solution; 1% foam; 1% gel; 1% lotion
- Clindamycin Phosphate-Benzoyl Peroxide 1-5%; 1.2-2.5% & 1.2-5% gel
- Dapsone 5% & 7.5% gel
- Doxycycline monohydrate 100mg capsules
- Erythromycin 2% solution; 2% gel, 2% pads
- Isotretinoin 10 mg, 20 mg, 25 mg, 30 mg, 35 mg & 40 mg cap
- Pimecrolimus 1% cream*
- Sulfacetamide Sodium 10% lotion; 10% cream; 10% cleansing gel
- Tacrolimus 0.03% & 0.1% ointment*
- Tazarotene 0.05% & 0.1% cream*
- Tretinoin 0.025% & 0.1% cream; 0.01%, 0.025%, & 0.05% gel; 0.04%, 0.06%, 0.08% & 0.1% microsphere gel

*Prior authorization is not required for members <21 years of age

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 Trillium Oregon Health that treatment is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Acne (must meet all)**:**

1. Member meets one of the following (a, b, or c)
   a. Age <21 years;
   b. Member has Young Adults with Special Health Care Needs (YSHCN) coverage and was born in or after the year 2004;
   c. Diagnosis of severe acne (meets ANY of the following):
      i. Member has diagnosis of acne conglobata with recurrent abscess or communicating sinuses;
      ii. Member has diagnosis of acne fulminans;
      iii. Member has severe acne as defined by presence of persistent or recurrent inflammatory nodules and cysts with ongoing scarring;
2. If request is for non-preferred option member has previously tried and failed at least a 6 month trial of a preferred agent listed above;
3. Dose does not exceed FDA approved dose;

Approval duration: up to 12 months

B. Other diagnoses/indications (must meet 1 or 2):

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the PDL the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the PDL the non-formulary policy for the relevant line of business: OR.CP.PMN.1001 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Acne (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*

2. If request is for a dose increase, new dose does not exceed FDA approved dose for indication;

Approval duration: up to 12 months

B. Other diagnoses/indications (must meet 1 or 2):
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the PDL the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the PDL the non-formulary policy for the relevant line of business: OR.CP.PMN.1001 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – CP.PMN.53 for Medicaid or evidence of coverage documents;

IV. References

1. Acne Medications. Oregon Health Plan Current Drug Use Criteria. Available at: http://orpdl.org/drugs/index.php. Accessed April 18, 2025.
2. Guideline Note 65 Severe Cystic Acne. Oregon Health Plan Prioritized List. Available at www.oregon.gov/oha/HPA/DSI-HERC/Pages/Prioritized-List.aspx. Accessed April 1, 2024.
3. Guideline Note 132 Acne Conglobata and Acne Fulminans. Oregon Health Plan Prioritized List. Available at www.oregon.gov/oha/HPA/DSI-HERC/Pages/Prioritized-List.aspx. Accessed April 18, 2025.
4. Micromedex® Healthcare Series [Internet database]. Greenwood Village, Colo: Thomson Healthcare. Updated periodically. Accessed April 18, 2025.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created; adapted from previously approved policy TCHP.PHAR.1902 Severe Acne	03.18.22	04.07.22
Added section I.B. to mirror FFS coverage expansion for mild-moderate acne for OHP members <21 years of age due to EPSDT waiver expiration	02.02.23	02.20.23
Template changes applied to other diagnoses/indications and continued therapy section	03.15.23	04.06.23
2Q 2024 annual review: no significant changes; references reviewed and updated.	04.01.24	05.21.24

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Added standard YSHCN language to I.A. for new 2025 OHP program coverage.	10.16.24	11.19.24
2Q 2024 annual review: no significant changes; updated initial approval criteria for severe cystic acne per updated language in Guideline Note 65 of the OHP Prioritized List; references reviewed and updated.	04.18.25	06.10.25

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.