Initial Approval: January 8, 2014
Revised dates: April 12, 2017

CRITERIA FOR PRIOR AUTHORIZATION

Rosacea Agents

PROVIDER GROUP Pharmacy

MANUAL GUIDELINES The following drug requires prior authorization:
Azelaic acid (Finacea®)
Brimonidine (Mirvaso®)
Ivermectin (Soolantra®)
Oxymetazoline (Rhofade®)
Metronidazole (MetroCream®, Metrogel®, MetroLotion®, Noritate®, Rosadan®)

CRITERIA FOR ROSACEA AGENTS: (must meet all of the following)

- Patient must be 18 years of age or older
- Must be prescribed by or in consultation with a dermatologist
- Patient must have one of the following:
  - persistent (nontransient) facial erythema of rosacea (metronidazole products, Mirvaso, Rhofade)
  - Inflammatory lesions of rosacea (Finacea, metronidazole products, Soolantra)

LENGTH OF APPROVAL 6 months

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DRUG UTILIZATION REVIEW COMMITTEE CHAIR

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DATE

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PHARMACY PROGRAM MANAGER
DIVISION OF HEALTH CARE FINANCE
KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

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DATE