Louisiana ~~Fee-for-Service~~ Medicaid
Acne Agents, Topical

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request clinical authorization for acne agents, topical (preferred and non-preferred). ~~A diagnosis of psoriasis on a pharmacy claim for tazarotene cream or gel will bypass the age limit applied to acne agents.~~ Criteria for approval of ~~T~~tazarotene~~, when used~~ for ~~a diagnosis of~~ psoriasis ~~(see criteria~~is found on the next page~~. 2), requires a diagnosis code at POS. The diagnosis code (L40*) must be communicated to the pharmacy in order to be submitted on the pharmacy claim. A diagnosis of psoriasis on a pharmacy claim for tazarotene cream or gel will bypass the age limit applied to acne agents. See page 2 for approval criteria for non-preferred tazarotene used for psoriasis.~~

~~* Any number or letter or combination of UP TO FOUR numbers and letters of an assigned ICD-10 diagnosis code.~~

~~Acne agents listed on the PDL/NPDL are restricted to use in recipients younger than 21 years of age. Pharmacy claims for acne agents will not be allowed to process through the POS System for recipients 21 years of age or older.~~

~~Requests to initiate~~ For Acne

Approval Criteria ~~treatment must meet ALL of the following criteria for a diagnosis of acne:~~

- The recipient is less than 21 years of age on the date of the request; **AND**
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- The severity is Grade 3 moderately severe nodulocystic acne (numerous papules and pustules; the occasional inflamed nodule; the back and chest may also be affected) or Grade 4 severe nodulocystic acne (numerous large, painful pustules and nodules; inflammation); **AND**
- For tazarotene used for acne, the product requested is either 0.1% cream or 0.1% gel; **AND**
- If the request is for a non-preferred agent - **ONE** of the following is required:
    - The recipient has had a *treatment failure* with at least one preferred product; **OR**
    - The recipient has had an *intolerable side effect* to at least one preferred product; **OR**
    - The recipient has a *documented contraindication(s)* to all of the preferred products that are appropriate to use for the condition being treated; **OR**
    - There is *no preferred product that is appropriate* to use for the condition being treated; **AND**
- By submitting the authorization request, the prescriber attests to the following:
    - The prescribing information for the requested medication has been thoroughly reviewed, including any Black Box Warning, Risk Evaluation and Mitigation Strategy (REMS), contraindications, minimum age requirements, recommended dosing, and prior treatment requirements; **AND**
    - All laboratory testing and clinical monitoring recommended in the prescribing information have been completed as of the date of the request and will be repeated as recommended; **AND**
    - The recipient has no concomitant drug therapies or disease states that would limit the use of the requested medication and will not be receiving the requested medication in

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combination with any medication that is contraindicated or not recommended per FDA labeling.

~~Requests to continue treatment or for r~~**Reauthorization** ~~must meet the following~~ **criteria for a diagnosis of acne**~~:~~

- The recipient continues to meet all initial criteria with improved disease severity; **AND**
- The request states the current acne severity, which is an improvement from baseline.

Duration of initial and reauthorization approval for acne: 12 months (or up to the recipient's 21st birthday, whichever is less)

For Tazarotene Cream or Gel for Psoriasis

Criteria for Both Initial Approval and Reauthorization~~Requests to initiate or continue treatment f or tazarotene cream or gel must meet ALL of the following criteria for a diagnosis of psoriasis (see the Dermatology – Antipsoriatics, Topical section of the PDL/NPDL):~~

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- If the request is for a non-preferred agent - **ONE** of the following is required:
  - The recipient has had a *treatment failure* with at least one preferred topical antipsoriatic product (see Dermatology – Antipsoriatics, Topical on PDL); **OR**
  - The recipient has had an *intolerable side effect* to at least one preferred topical antipsoriatic product (see Dermatology – Antipsoriatics, Topical on PDL); **OR**
  - The recipient has a *documented contraindication(s)* to all of the preferred topical antipsoriatic products that are appropriate to use for the condition being treated (see Dermatology – Antipsoriatics, Topical on PDL); **OR**
  - There is *no preferred topical antipsoriatic product that is appropriate* to use for the condition being treated (see Dermatology – Antipsoriatics, Topical on PDL); **AND**
- By submitting the authorization request, the prescriber attests to the following:
  - The prescribing information for the requested medication has been thoroughly reviewed, including any Black Box Warning, Risk Evaluation and Mitigation Strategy (REMS), contraindications, minimum age requirements, recommended dosing, and prior treatment requirements; **AND**
  - All laboratory testing and clinical monitoring recommended in the prescribing information have been completed as of the date of the request and will be repeated as recommended; **AND**
  - The recipient has no concomitant drug therapies or disease states that would limit the use of the requested medication and will not be receiving the requested medication in combination with any medication that is contraindicated or not recommended per FDA labeling.

~~Duration of initial and reauthorization approval for acne: 12 months (or up to the recipient's 21st birthday, whichever is less)~~

Duration of initial and reauthorization approval for tazarotene cream or gel for psoriasis: 12 months

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References

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Revision	**Date**
Removed POS information, formatting changes, updated references	July 2020

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