Premier Health Plan

POLICY AND PROCEDURE

POLICY TITLE: ***Mirvaso (brimonidine topical gel) & Rhofade (oxymetazoline hcl)***
DEPARTMENT: **Clinical Pharmacy Services- Utilization Management**
ORIGINAL DATE: ***October 2013 (as adopted from UPMC Health Plan)***

Last P & T Committee Approval Date: February *2018*

Product Applicability: *mark all applicable products below:*

COMMERCIAL	[ ] HMO	[ ] PPO	*Products*: [ ] Small [ ] Indiv. [ ] Large	*Exchange*: [ ] Shop [ ] Indiv.	[x] All
OTHER	[x] Self-funded/ASO				

PURPOSE

The purpose of this policy is to define the prior authorization process for Mirvaso (brimonidine topical gel).

Mirvaso (brimonidine topical gel) is indicated for the topical treatment of persistent erythema of rosacea in adults age 18 years of age or older.

DEFINITIONS

N/A

POLICY

It is the policy of the Health Plan to maintain a prior authorization process that promotes appropriate utilization of specific drugs with potential for misuse or limited indications. This process involves a review using Food and Drug Administration (FDA) criteria to make a determination of Medical Necessity, and approval by the Pharmacy & Therapeutics Committee of the criteria for prior authorization, as described in RX.002 Pharmacy and Therapeutics Committee and RX.003-Prior Authorization Process.

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The drugs, Mirvaso (brimonidine topical gel) and Rhofade (oxymetazolein). are subject to the prior authorization process.

PROCEDURE

Initial Authorization Criteria:

Must meet all of the criteria listed below:

- Must be prescribed by a dermatologist
- Must be age 18 years or older
- Must have a diagnosis of persistent erythema associated with rosacea
- Must have an adequate trial of at least two other generic medications that are used for the treatment of rosacea (e.g. metronidazole, sodium sulfacetamide/sulfur, tretinoin, adapalene, doxycycline)

Limitations:

Length of Authorization (if above criteria met)	
Initial Authorization	Up to duration of member's membership with plan
Reauthorization	N/A

If the established criteria are not met, the request is referred to a Medical Director for review.

REFERENCES

1. Mirvaso [prescribing information]. Fort Worth, TX: Galderma Laboratories, L.P. August 2013.
2. Goldgar C et al. Treatment Options for Acne Rosacea. *Am Family Physician*. 2009; 80(5):461-468, 505
3. Mirvaso [AMCP Dossier]. Fort Worth, TX: Galderma Laboratories, L.P. August 2013.
4. Rhofade [prescribing information]. Irvine, CA: Allergan; 2017.
5. Effective and evidence-based management strategies for rosacea: summary of a Cochrane systematic review. Zuuren EJ, Kramer SF, Carter BR, et al. Brit Assoc Derm 2011(165):760-781.

RECORD RETENTION

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Records Retention Policy and Procedure.

REVIEW HISTORY

DESCRIPTION OF REVIEW / REVISION	DATE APPROVED
Annual review	*02/16, 02/17, 02/18*
Addition of Rhofade	*04/17*

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