PRIOR AUTHORIZATION CRITERIA

DRUG CLASS	RETINOIDS (ALL TOPICAL)
BRAND NAME (generic)	
(901010)	
	(tretinoin)
	ATRALIN
	(tretinoin)
	Ανιτα
	(tretinoin)
	RETIN-A
	(tretinoin)
	RETIN-A MICRO
	(tretinoin)
	VELTIN
	(clindamycin/tretinoin)
	ZIANA
	(clindamycin/tretinoin)
Status: CVS Caremark Criteria	
Type: Initial Prior Authorization	

POLICY

FDA-APPROVED INDICATIONS

Atralin, Avita, Retin-A, and Retin-A Micro, are indicated for topical application in the treatment of acne vulgaris. Veltin and Ziana are indicated for the topical treatment of acne vulgaris in patients 12 years or older. Altreno (tretinoin) lotion, 0.05% is indicated for the topical treatment of acne vulgaris in patients 9 years of age and older.

<u>Compendial Use</u> Keratosis follicularis (Darier's disease, Darier-White disease) ^{11,14,15}

COVERAGE CRITERIA

The requested drug will be covered with prior authorization when the following criteria are met:

- The patient has the diagnosis of acne vulgaris
- OR

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The patient has the diagnosis of keratosis follicularis (Darier's disease, Darier-White disease)

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