AETNA BETTER HEALTH® Coverage Policy/Guideline				
Name:	Tazarotene Cream 0.1%		Page:	1 of 2
Effective Date:	5/29/2025		Last Review Date:	5/1/2025
Applies to:	☐Illinois ☒Florida Kids	☒New Jersey ☒Pennsylvania Kids	☒Maryland ☒ Virginia	

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Tazarotene Cream 0.1% under the patient's prescription drug benefit.

Description:

FDA-Approved Indication

Plaque Psoriasis
Tazarotene cream 0.1% is indicated for the topical treatment of patients with plaque psoriasis.

Acne Vulgaris
Tazarotene cream 0.1% is also indicated for the topical treatment of patients with acne vulgaris.

Applicable Drug List:

Tazarotene Cream 0.1%

Policy/Guideline:

Criteria for Initial Approval:

Plaque Psoriasis
Authorization may be granted when the requested drug is being prescribed for the treatment of plaque psoriasis when ALL of the following criteria are met:

- The plaque psoriasis affects less than or equal to 20 percent of the patient's body surface area (BSA).
- The patient meets ONE of the following:
  - The patient has experienced an inadequate treatment response to at least ONE topical corticosteroid [NOTE: The patient may continue to use a corticosteroid product (e.g., clobetasol, fluocinonide, mometasone, triamcinolone, etc.).]
  - The patient has experienced an intolerance to at least ONE topical corticosteroid.
  - The patient has a contraindication that would prohibit a trial of ALL topical corticosteroids.

CONTINUATION OF THERAPY

Plaque Psoriasis
Authorization may be granted when the requested drug is being prescribed for the treatment of plaque psoriasis when ALL of the following criteria are met:

- The plaque psoriasis affects less than or equal to 20 percent of the patient's body surface area (BSA).

- The patient has achieved or maintained a positive clinical response as evidenced by improvement (e.g., clear or almost clear outcome, patient satisfaction, etc.)

Approval Duration and Quantity Restrictions:

Initial Approval: 3 Months

Renewal Approval: 12 Months

Quantity Level Limit: Reference Formulary for drug specific quantity level limits

References:

1. Tazorac Cream [package insert]. Exton, PA: Almirall, LLC.; August 2019.
2. Tazorac Gel [package insert]. Exton, PA: Almirall, LLC.; August 2019.
3. Lexicomp Online, AHFS DI (Adult and Pediatric) Online. Waltham, MA: UpToDate, Inc.; 2024. https://online.lexi.com. Accessed May 29, 2024.
4. Micromedex® (electronic version). Merative, Ann Arbor, Michigan, USA. Available at: https://www.micromedexsolutions.com/ (cited: *05/29/2024*).
5. Elmets C, Korman N, Prater E, et al. Joint AAD-NPF Guidelines of care for the management and treatment of psoriasis with topical therapies and alternative medicine modalities for psoriasis severity measures. *J Am Acad Dermatol* 2021; 84:432-70.