New Hampshire Medicaid Fee-for-Service Program Topical Retinoids (Acne Treatment) Criteria

Approval Date: November 21, 2024

Medication

Brand Name	Generic Name	Strengths
	adapalene	0.1% cream, 0.3% gel
	adapalene/benzoyl peroxide	0.1/2.5%, 0.3/2.5%
Ziana®	clindamycin/tretinoin	1.2%/0.025% gel
	tazarotene	0.05% gel, 0.1% gel
	tazarotene	0.1% cream
Fabior®	tazarotene	0.1% foam
Arazlo®	tazarotene	0.045% lotion
Altreno®	tretinoin	0.05% lotion
Atralin®	tretinoin	0.05% gel
	tretinoin	0.025% cream, 0.025% gel
Retin-A®	tretinoin	0.01% gel, 0.025% gel, 0.025% cream, 0.05% cream, 0.1% cream
Retin-A Micro®	tretinoin microspheres	0.04% gel, 0.06% gel, 0.08% gel, 0.1% gel

Patients under the age of 40 are exempt from prior approval requirement for preferred medications only.

Criteria for Approval

1. Patient age ≥ 40 years: **AND**
2. Diagnosis is considered a non-cosmetic medical condition such as acne vulgaris, psoriasis, precancerous skin lesions; **AND**
3. Diagnosis is not being requested solely for cosmetic purposes such as photoaging, wrinkling, hyperpigmentation, sun damage, or melasma.

Non-preferred drugs on the Preferred Drug List (PDL) require additional prior authorization.

Criteria for Denial

1. Prior approval will be denied if the approval criteria are not met

Length of Authorization: 12 months

Revision History

Reviewed by	Reason for Review	Date Approved
DUR Board	New	06/19/2023
Commissioner Designee	Approval	06/29/2023
DUR Board	Revision	10/15/2024
Commissioner Designee	Approval	11/21/2024