UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2025 P 2307-3
Program	Prior Authorization/Medical Necessity
Medication	Aklief® (trifarotene) cream
P&T Approval Date	6/2023, 6/2024, 6/2025
Effective Date	9/1/2025

1. Background:

Aklief (trifarotene) cream is a retinoid indicated for the topical treatment of acne vulgaris in patients 9 years of age and older.

2. Coverage Criteria[a]:

A. **Initial Authorization**

1. **Aklief** will be approved based on **both** of the following criteria:

   a. Diagnosis of acne vulgaris

   -AND-

   b. History of failure, contraindication, or intolerance to **one** of the following:

      1) Over-the-counter Differin gel
      2) Tretinoin cream (generic Retin-A)

   Authorization will be issued for 12 months

B. **Reauthorization**

1. **Aklief** will be approved based on the following criterion:

   a. Documentation of positive clinical response to therapy

   Authorization will be issued for 12 months

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.

- Supply limits may be in place.

4. References:

1. Aklief [package insert]. Dallas, TX: Galderma; October 2023.
2. Reynolds, RV, Yeung, H, Cheng, CE, et. al. Guidelines of care for the management of acne vulgaris. *J Am Acad Dermatol*. 2024; 90:1006.e1-e30.

Program	Prior Authorization/Medical Necessity - Aklief
Change Control	
Date	Change
6/2023	New program
6/2024	Annual review. Updated initial authorization to 12 months and updated references.
6/2025	Annual review. No changes.