



UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2021 P 1313-2
Program	Prior Authorization-Notification
Medication	Mirvaso (brimonidine gel), Rhofade (oxymetazoline cream)
P&T Approval Date	5/2020, 5/2021
Effective Date	8/1/2021; Oxford only: 8/1/2021

1. Background:

Mirvaso[®] (brimonidine) 0.33% topical gel and Rhofade[®] (oxymetazoline) 1% topical cream are alpha-adrenergic agonists indicated for the topical treatment of persistent (nontransient) erythema of rosacea in adults.

2. Coverage Criteria:

A. Initial Authorization

1. **Mirvaso and Rhofade** will be approved based on **both** of the following criteria:

a. Diagnosis of rosacea

-AND-

b. Treatment of persistent facial erythema

Authorization will be issued for 12 months.

B. Reauthorization

1. **Mirvaso and Rhofade** will be approved based on the following criterion:

a. Documentation of positive clinical response to therapy.

Authorization will be issued for 12 months.

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
- Step Therapy may be in place

4. References:

1. Mirvaso [package insert]. Fort Worth, TX; Galderma Laboratories, L.P.; June 2018.
2. Rhofade [package insert]. Charleston SC: EPI Health; November 2019.

Program	Notification – Rosacea
Change Control	
5/2020	New program.
5/2021	Annual review. Updated references.