UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2025 P 2192-6
Program	Prior Authorization/Medical Necessity
Medications	Tazorac® (tazarotene)
P&T Approval Date	5/2020, 5/2021, 5/2022, 5/2023, 3/2024, 3/2025
Effective Date	6/1/2025

1. Background:

Tazorac (tazarotene) 0.05% and 0.1% cream and gel are indicated for the topical treatment of plaque psoriasis. In addition, the 0.1% cream and gel are indicated for the topical treatment of patients with facial acne vulgaris of mild to moderate severity. For localized plaque-psoriasis, topical corticosteroids and topical calcipotriene (Dovonex) are recommended as initial therapy. For uncontrolled localized plaque-psoriasis anthralin (Anthra-Derm) or tazarotene (Tazorac) can be added.

The use of a topical retinoid is recommended as monotherapy primarily in noninflammatory acne, or in combination with topical or oral antimicrobials in patients with mixed or primarily inflammatory acne lesions. Over-the-counter medications and other prescription medications for the treatment of acne are available. Coverage of Tazorac will only be provided for plaque psoriasis after meeting these requirements.

2. Coverage Criteria[a]:

A. **Initial Authorization**

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

   a. Diagnosis of plaque psoriasis

   -AND-

   b. History of failure, contraindication, or intolerance to a topical corticosteroid (e.g., clobetasol, halobetasol)

Authorization will be issued for 12 months.

B. **Reauthorization**

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

   a. Documentation of positive clinical response to therapy

Reauthorization 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. Tazorac [package insert]. Exton, PA; Almirall, LLC: August 2019.
2. Pardasani, AG, Feldman, SR, Clark, AR. Treatment of Psoriasis: An Algorithm-Based Approach for Primary Care Physicians. Am Fam Physician. 2000;61(3):725-33.
3. Reynolds RV, et. al. Guidelines of care for the management of acne vulgaris. *J Am Acad Dermatol.* 2024; 90(5): 1-30.
4. Elmets, CA, et. al. Joint AAD-NPF Guidelines of care for the management and treatment of psoriasis with topical therapy and alternative medicine modalities for psoriasis severity measures. *J Am Acad Dermatol.* 2021; 84(2): 432-70.

Program	Prior Authorization/Medical Necessity - Tazorac
Change Control	
Date	Change
5/2020	New program
5/2021	Annual review. Updated references.
5/2022	Annual review. Updated references.
5/2023	Annual review. Updated references.
3/2024	Annual review. Updated initial authorization to 12 months.
3/2025	Annual review. Updated references.