| Market Applicability | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Market** | **DC** | **FL & FHK** | **FL MMA** | **FL LTC** | **GA** | **KS** | **KY** | **MD** | **NJ** | **NV** | **NY** | **TN** | **TX** | **WA** |
| **Applicable** | X | X | NA | NA | X | NA | X | X | X | X | X | NA | NA | X |

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# Cosmetic Anti-Aging

| Override(s) | Approval Duration |
|---|---|
| Prior Authorization<br>Quantity Limit | 1 year |

| Medications | Comments | Quantity Limit |
|---|---|---|
| tretinoin gel 0.01% and 0.025% | Preferred | May be subject to quantity limits |
| tretinoin gel micro 0.1% | | |
| tretinoin cream 0.025%, 0.05%, 0.1% | | |
| Altreno (tretinoin) | Non-Preferred | |
| Atralin (tretinoin) | | |
| Avita (tretinoin) | | |
| Refissa (tretinoin) | | |
| Renova (tretinoin/emollient) | | |
| Retin-A (tretinoin) | | |
| Retin-A Micro (tretinoin) | | |
| Tretin-X (tretinoin) | | |
| tretinoin gel 0.05% | | |

**All pump formulations are non-preferred**

## APPROVAL CRITERIA

Requests for preferred topical tretinoin agents [tretinoin gel (0.01%, 0.025%), tretinoin gel micro (0.1%), or tretinoin cream (0.025%, 0.05%, or 0.1%)] may be approved for the following:

I. Individual has one of the following diagnoses:
   A. Acne; **OR**
   B. Rosacea; **OR**
   C. Molluscum contagiosum (only 3 weeks of treatment).

Requests for non-preferred topical tretinoin agents (Altreno, Atralin, Avita, Retin-A, Retin-A Micro, Tretin-X, tretinoin gel 0.05%) may be approved for the following:

| Market Applicability | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Market** | **DC** | **FL & FHK** | **FL MMA** | **FL LTC** | **GA** | **KS** | **KY** | **MD** | **NJ** | **NV** | **NY** | **TN** | **TX** | **WA** |
| **Applicable** | X | X | NA | NA | X | NA | X | X | X | X | X | NA | NA | X |

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I. Individual has one of the following diagnoses:
   A. Acne; **OR**
   B. Rosacea; **OR**
   C. Molluscum contagiosum (only 3 weeks of treatment);

**AND**

II. Individual has had a prior trial and inadequate response to two preferred generic topical tretinoin agents [tretinoin gel (0.01%, 0.025%),tretinoin gel micro (0.1%) or tretinoin cream (0.025%, 0.05%, or 0.1%)] if the request is for (Altreno, Atralin, Avita, , Retin-A, Retin-A Micro, Tretin-X, tretinoin gel 0.05%);

**AND**

III. The non preferred agent is being used for the same medical reason as the preferred agents and the same clinical benefit is not expected with the preferred agents.

Topical tretinoin agents (Altreno, Atralin, Avita, Refissa, Renova, Retin-A, Retin-A Micro, Tretin-X, tretinoin gel, and tretinoin cream) may **not** be approved for cosmetic purposes such as, but not limited to the following:

I. Photoaging; **OR**
II. Wrinkles; **OR**
III. Hyperpigmentation; **OR**
IV. Sun damage; **OR**
V. Melasma.

Refissa (tretinoin) and Renova (tretinoin) may not be approved for the following:

I. Acne; **OR**
II. Rosacea; **OR**
III. Molluscum contagiosum.

| State Specific Mandates | | |
|---|---|---|
| State name | Date effective | Mandate details (including specific bill if applicable) |
| N/A | N/A | N/A |

| Market Applicability | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Market** | **DC** | **FL & FHK** | **FL MMA** | **FL LTC** | **GA** | **KS** | **KY** | **MD** | **NJ** | **NV** | **NY** | **TN** | **TX** | **WA** |
| **Applicable** | X | X | NA | NA | X | NA | X | X | X | X | X | NA | NA | X |

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**Key References**:


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