Clinical Policy Title:	oxymetazoline hydrochloride
Policy Number:	RxA.267
Drug(s) Applied:	Rhofade®
Original Policy Date:	02/07/2020
Last Review Date:	8/28/2024
Line of Business Policy Applies to:	All lines of business (except Medicare)

Criteria

I. Initial Approval Criteria

A. Facial Erythema Associated with Rosacea (must meet all):

1. Diagnosis of persistent facial erythema associated with rosacea;
2. If papules or pustules are present, a failure of or concomitant treatment with any of the following agents, unless contraindicated or clinically significant adverse effects are experienced: topical metronidazole, oral doxycycline, ivermectin cream or azelaic acid.

Approval Duration

All Lines of Business (except Medicare): 12 months

II. Continued Therapy Approval

A. Facial Erythema Associated with Rosacea (must meet all)**:**

1. Auto-approval based on lookback functionality within the past 120 days as a proxy for member responding positively to therapy.

Approval Duration

All Lines of Business (except Medicare): 12 months

References

1. National Rosacea Society. Rosacea treatment algorithms. Available at: https://www.rosacea.org/physicians/treatmentalgorithms. Accessed August 28, 2024.

Review/Revision History	Review/Revision Date	P&T Approval Date
Policy established.	01/2020	02/07/2020
Policy was reviewed: 1. Clinical Policy Title was updated. 2. Drug(s) Applied was updated. 3. Line of Business Policy Applies to was updated. 4. Continued Therapy criteria II.A.1 was rephrased to "Currently receiving medication that has been authorized by RxAdvance..." 5. Commercial approval duration and	07/13/2020	09/14/2020

Medicaid approval duration updated. 6. References were updated. 7. Reworded dosing regimen to: “Apply a pea-size amount once daily in a thin layer to cover the entire face (forehead, chin, nose, and each cheek) avoiding the eyes and lips.” 8. Updated Initial Approval Criteria #3 – removed Finacea and added azelaic acid.		
Policy was reviewed: 1. Clinical Policy Title was updated. 2. Continued therapy criteria II.A.1 was rephrased to “Member is currently receiving medication that has been authorized by RxAdvance..” 3. References were reviewed and updated.	04/12/2021	06/10/2021
Policy was reviewed: 1. References were reviewed and updated.	01/25/2022	04/18/2022
Policy was reviewed: 1. Initial Approval Criteria I.A.4:Updated to add ivermectin cream as an option for failure. 2. References were reviewed and updated.	12/30/2022	04/13/2023
Policy was reviewed.	10/19/2023	10/19/2023
Policy was reviewed: 1. Removed age restrictions. 2. Removed dose restrictions. 3. Updated Continued therapy approval with auto-approval based on lookback functionality within the past 120 days. 4. Removed reauthorization requirement for positive response to therapy. 5. Updated approval duration verbiage. 6. References were reviewed and updated.	8/28/2024	9/13/2024