MEDICAL MUTUAL®

Drug Policy

Policy: **CC**	**Topical Acne – Cleansers** **Preferred Step Therapy Policy**	**Annual Review Date: 03/20/2025** **Last Revised Date: 03/20/2025**

OVERVIEW

Many topical products are available for the **treatment of acne vulgaris**.[1,2] Benzoyl peroxide-containing products are generally indicated for the treatment and prevention of mild to moderate acne vulgaris. Sulfacetamide sodium have antimicrobial properties and sulfur have antiseptic properties which aid in the removal of keratin and drying of the skin and are available in a variety of strengths and vehicles. These products (sulfacetamide/sulfur) are additionally used for acne rosacea and seborrheic dermatitis. Acne treatment guidelines do not prefer any of the brand name products over similar generic products.[3]

The topical products for treatment of acne are available in multiple formulations.[1,2] Creams and lotions may be best for dry or sensitive skin and gels or foams may be best for more oily skin (although newer aqueous gels may also be suitable for sensitive skin).[3]

POLICY STATEMENT

A step therapy program has been developed to encourage the use of a generic preferred product prior to the use of a non-preferred product. If the step therapy rule is not met for a non-preferred agent at the point of service, coverage will be determined by the step therapy criteria below. All approvals are provided for 12 months in duration. (Note: For the purpose of this policy, a topical cleanser is defined as a cleanser, solution, liquid, wash, foaming cloth, cleansing cloth or soap).

Automation: Patients with a history of one preferred product drug within the 130-day look-back period are excluded from step therapy.

Preferred: Generic prescription topical acne cleansers containing benzoyl peroxide or sulfacetamide/sulfur.

Non-Preferred: Brand name topical acne cleansers containing benzoyl peroxide or sulfacetamide/sulfur.

CRITERIA

1. If the patient has tried a preferred product, approve a non-preferred product

Initial Approval/ Extended Approval.
A) *Initial Approval:* 2 years (730 days)
B) *Extended Approval:* 2 years (730 days)

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Step Therapy Exception Criteria
In certain situations, the patient is not required to trial preferred agents. Approve for 1 year if the patient meets the following (A, B, or C):

A. The patient has an atypical diagnosis and/or unique patient characteristics which prevent use of all preferred agents. If so, please list diagnosis and/or patient characteristics [documentation required]; **OR**
B. The patient has a contraindication to all preferred agents. If so, please list the contraindications to each preferred agent [documentation required]; **OR**
C. The patient is continuing therapy with the requested non-preferred agent after being stable for at least 90 days [verification in prescription claims history required] or, if not available, [verification by prescribing physician required] AND meets ONE of the following:
    1. The patient has at least 130 days of prescription claims history on file and claims history supports that the patient has received the requested non-preferred agent for 90 days within a 130-day look-back period AND there is no generic equivalent available for the requested nonpreferred product (i.e. AA-rated or AB-rated to the requested nonpreferred product); OR
    2. When 130 days of the patient's prescription claims history file is unavailable for verification, the prescriber must verify that the patient has been receiving the requested non-preferred agent for 90 days AND that the patient has been receiving the requested non-preferred agent via paid claims (i.e. the patient has NOT been receiving samples or coupons or other types of waivers in order to obtain access to the requested non-preferred agent) AND there is no generic equivalent available for the requested nonpreferred product (i.e. AA-rated or AB-rated to the requested nonpreferred product).

Documentation Required: When documentation is required, the prescriber must provide written documentation supporting the trials of these other agents, noted in the criteria as [documentation required]. Documentation should include chart notes, prescription claims records, and/or prescription receipts.

Approval Duration: All approvals for continuation of therapy are provided for 1 year unless noted otherwise below. In cases where the initial approval is authorized in months, 1 month is equal to 30 days.

Documentation Requirements:

The Company reserves the right to request additional documentation as part of its coverage determination process. The Company may deny reimbursement when it has determined that the drug provided or services performed were not medically necessary, investigational or experimental, not within the scope of benefits afforded to the member and/or a pattern of billing or other practice has been found to be either inappropriate or excessive. Additional documentation supporting medical necessity for the services provided must be made available upon request to the Company. Documentation requested may include patient records, test results and/or credentials of the provider ordering or performing a service. The Company also reserves the right to modify, revise, change, apply and interpret this policy at its sole discretion, and the exercise of this discretion shall be final and binding.

REFERENCES

1. Facts and Comparisons® Online. Wolters Kluwer Health, Inc.; 2024. Available at: https://fco.factsandcomparisons.com/lco/action/home. Accessed on December 12,2024. Search terms: benzoyl peroxide, clindamycin, sulfacetamide/sulfur.
2. Clinical Pharmacology © 2024. Available at https://www.clinicalkey.com/pharmacology/. Accessed on December 12, 2024. Search Terms: benzoyl peroxide and sulfur/sulfacetamide.
3. Reynolds RV, Yeung H, Cheng CE, et al. Guidelines of care for the management of acne vulgaris. *J Am Acad Dermatol*. 2024;90(5):1006.e1-1006.e30.