



**Drug Name:** Solosec Step Therapy Criteria

**Effective Date:** 6/7/2019

**Last Revision Date:** 6//2019, 7/2020

<b>Drug Name:</b>	Solosec (secnidazole)
<b>Required Medical Information:</b>	<ul style="list-style-type: none"><li>• Member has failed therapy with at least two formulary alternatives (e.g. Clindamycin phosphate vaginal cream 2%, metronidazole (tablet, vaginal gel 0.75%), tinidazole).</li></ul>
<b>Coverage Duration:</b>	<b>Initial:</b> 1 month <b>Quantity Limit:</b> single 2-gram packet of granules per treatment