PRIOR AUTHORIZATION CRITERIA

DRUG CLASS	RETINOIDS (ALL TOPICAL)
BRAND NAME (generic)	
(90000)	ALTRENO
	(tretinoin)
	ATRALIN
	(tretinoin)
	ΑΥΙΤΑ
	(tretinoin)
	RETIN-A
	(tretinoin)
	RETIN-A MICRO
	(tretinoin)
	(demon)
	TRETIN-X
	(tretinoin)
	VELTIN
	(clindamycin/tretinoin)
	(clindamycin/tretinoin)
Status: CVS Caremark Criteria	
Type: Initial Prior Authorization	

POLICY

FDA-APPROVED INDICATIONS

Atralin, Avita, Retin-A, Retin-A Micro, Tretin-X gel and Tretin-X cream are indicated for topical application in the treatment of acne vulgaris. The safety and efficacy of these products in the treatment of other disorders have not been established. Veltin and Ziana are indicated for the topical treatment of acne vulgaris in patients 12 years or older. Altreno (tretinoin) lotion, 0.05% is indicated for the topical treatment of acne vulgaris in patients 9 years of age and older.

COVERAGE CRITERIA

The requested drug will be covered with prior authorization when the following criteria are met:

• The patient has the diagnosis of acne vulgaris

Tretinoins (Topical) Policy 237-A 06-2018

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REFERENCES

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