UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2023 P 1313-4
Program	Prior Authorization-Notification
Medication	Mirvaso (brimonidine gel), Rhofade (oxymetazoline cream)
P&T Approval Date	5/2020, 5/2021, 5/2022, 4/2023
Effective Date	7/1/2023; Oxford only: 7/1/2023

1. Background:
Mirvaso® (brimonidine) 0.33% topical gel and Rhofade® (oxymetazoline) 1% topical cream are alpha-adrenergic agonists indicated for the topical treatment of persistent (nontransient) erythema of rosacea in adults.

2. Coverage Criteria[a]:

A. Initial Authorization

1. **Mirvaso or Rhofade** will be approved based on the following criterion:

   a. Diagnosis of rosacea

   Authorization will be issued for 12 months.

B. Reauthorization

1. **Mirvaso or Rhofade** will be approved based on the following criterion:

   a. Documentation of positive clinical response to therapy.

   Authorization will be issued for 12 months.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Rules:
- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place
- Step Therapy may be in place

4. References:

1. Mirvaso [package insert]. Fort Worth, TX; Galderma Laboratories, L.P.; December 2022.
2. Rhofade [package insert]. Wayne, PA: Aclaris Therapeutics; November 2018.

Program	Notification – Rosacea
Change Control	
5/2020	New program.
5/2021	Annual review. Updated references.
5/2022	Annual review. Updated references.
4/2023	Annual review. Removed requirement of persistent facial erythema. Added state mandate language.