PRIOR AUTHORIZATION POLICY

POLICY: Topical Alpha-Adrenergic Agonists for Rosacea – Brimonidine Prior Authorization Policy
- Mirvaso® (brimonidine gel, 0.33% – Galderma, generic)

REVIEW DATE: 1/31/2024

INSTRUCTIONS FOR USE

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. EACH COVERAGE REQUEST SHOULD BE REVIEWED ON ITS OWN MERITS. MEDICAL DIRECTORS ARE EXPECTED TO EXERCISE CLINICAL JUDGMENT AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

CIGNA NATIONAL FORMULARY COVERAGE:

OVERVIEW

Brimonidine 0.33% gel, an alpha$_2$-adrenergic agonist, is indicated for the topical treatment of persistent (non transient) **facial erythema of rosacea** in patients ≥ 18 years of age.[1]

Brimonidine 0.33% gel has been shown to decrease the erythema associated with rosacea; brimonidine 0.33% gel has not been shown to exert any beneficial effects on inflammatory lesions.[1-3]

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of brimonidine 0.33% gel. All approvals are provided for the duration noted below.

- **Mirvaso® (brimonidine gel, 0.33% – Galderma, generic)**

is(are) covered as medically necessary when the following criteria is(are) met for FDA-approved indication(s) or other uses with supportive evidence (if applicable):

FDA-Approved Indication

1. **Facial Erythema.** Approve for 1 year if the patient meets the following (A and B):
   A) Patient is ≥ 18 years of age; AND
   B) Patient has facial erythema due to rosacea.

CONDITIONS NOT COVERED

- **Mirvaso® (brimonidine gel, 0.33% – Galderma, generic)**

is(are) considered experimental, investigational or unproven for ANY other use(s) including the following (this list may not be all inclusive; criteria will be updated as new published data are available):

1. **Erythema Caused by Conditions Other Than Rosacea**.

REFERENCES

1. Mirvaso® topical gel [prescribing information]. Fort Worth, TX: Galderma; December 2022.
2. Del Rosso JQ, Thiboutot D, Gallo R, et al. Consensus recommendations from the American Acne & Rosacea Society on the management of rosacea, part 2: a status report on topical agents. *Cutis*. 2013;92(6):277-284.
3. Del Rosso JQ, Thiboutot D, Gallo R, et al. Consensus recommendations from the American Acne & Rosacea Society on the management of rosacea, part 5: a guide on the management of rosacea. *Cutis*. 2014;93(3):134-138.

HISTORY

Type of Revision	Summary of Changes	Review Date
New Policy	--	01/25/2023
Selected Revision	**Facial Erythema.** Step component of the PA has been removed. Policy was previously "Prior Authorization with Step" and it is now "Prior Authorization".	03/01/2023
Annual Revision	No criteria changes.	01/31/2024