



# Retinoids (topical) Prior Authorization Program Summary

## POLICY REVIEW CYCLE

**Effective Date**  
01-01-2026

**Date of Origin**

## POLICY AGENT SUMMARY PRIOR AUTHORIZATION

Target Brand Agent(s)	Target Generic Agent(s)	Strength	Targeted MSC	Available MSC	Final Age Limit	Preferred Status
Differin	adapalene cream	0.1 %	M ; N ; O ; Y	O ; Y		
Differin ; Differin pump	adapalene gel	0.1 % ; 0.3 %	M ; N ; O ; Y	O ; Y		
Differin	adapalene lotion	0.1 %	M ; N ; O ; Y	N		
Adapalene	adapalene soln	0.1 %	M ; N ; O ; Y	N		
Adapalene/benzoyl peroxid ; Epiduo ; Epiduo forte	adapalene-benzoyl peroxide gel ; adapalene-benzoyl peroxide pad	0.1-2.5 % ; 0.3-2.5 %	M ; N ; O ; Y	N ; O ; Y		
Arazlo ; Fabior ; Tazarotene	tazarotene (acne) foam ; tazarotene (acne) lotion	0.045 % ; 0.1 %	M ; N ; O ; Y	N		
Tazorac	Tazarotene Cream 0.1%	0.1 %	M ; N ; O ; Y	O ; Y		
Tazorac	tazarotene gel	0.05 % ; 0.1 %	M ; N ; O ; Y	O ; Y		
Altreno ; Atralin ; Retin-a ; Retin-a micro ; Retin-a micro pump ; Retinoic acid ; Retinoic acid-all trans ; Tretinoin ; Tretinoin (all-trans reti ; Tretinoin microsphere ; Tretinoin microsphere pum	tretinoin cream ; tretinoin gel ; tretinoin lotion ; tretinoin microsphere gel ; tretinoin powder	0.01 % ; 0.025 % ; 0.04 % ; 0.05 % ; 0.06 % ; 0.08 % ; 0.1 %	M ; N ; O ; Y	M ; N ; O ; Y		
Twynéo	tretinoin-benzoyl peroxide cream	0.1-3 %	M ; N ; O ; Y	N		
Aklief	trifarotene cream	0.005 %	M ; N ; O ; Y	N		

## CLIENT SUMMARY – PRIOR AUTHORIZATION

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Adapalene	adapalene soln	0.1 %	Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; TX HIM Annual 2025 ; TX HIM Annual 2026
Adapalene/benzoyl peroxid ; Epiduo ; Epiduo forte	adapalene-benzoyl peroxide gel ; adapalene-benzoyl peroxide pad	0.1-2.5 % ; 0.3-2.5 %	Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; TX HIM Annual 2025 ; TX HIM Annual 2026
Aklief	trifarotene cream	0.005 %	Basic ; Basic Annual ; Enhanced ; Enhanced

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
			Annual ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; TX HIM Annual 2025 ; TX HIM Annual 2026
Altreno ; Atralin ; Retin-a ; Retin-a micro ; Retin-a micro pump ; Retinoic acid ; Retinoic acid-all trans ; Tretinoin ; Tretinoin (all-trans reti ; Tretinoin microsphere ; Tretinoin microsphere pum	tretinoin cream ; tretinoin gel ; tretinoin lotion ; tretinoin microsphere gel ; tretinoin powder	0.01 % ; 0.025 % ; 0.04 % ; 0.05 % ; 0.06 % ; 0.08 % ; 0.1 %	Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; TX HIM Annual 2025 ; TX HIM Annual 2026
Arazlo ; Fabior ; Tazarotene	tazarotene (acne) foam ; tazarotene (acne) lotion	0.045 % ; 0.1 %	Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; TX HIM Annual 2025 ; TX HIM Annual 2026
Differin	adapalene cream	0.1 %	Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; TX HIM Annual 2025 ; TX HIM Annual 2026
Differin	adapalene lotion	0.1 %	Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; TX HIM Annual 2025 ; TX HIM Annual 2026
Differin ; Differin pump	adapalene gel	0.1 % ; 0.3 %	Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; TX HIM Annual 2025 ; TX HIM Annual 2026
Tazorac	Tazarotene Cream 0.1%	0.1 %	Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; TX HIM Annual 2025 ; TX HIM Annual 2026
Tazorac	tazarotene gel	0.05 % ; 0.1 %	Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; TX HIM Annual 2025 ; TX HIM Annual 2026
Twynéo	tretinoin-benzoyl peroxide cream	0.1-3 %	Basic ; Basic Annual ; Enhanced ; Enhanced

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
			Annual ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; TX HIM Annual 2025 ; TX HIM Annual 2026

## PRIOR AUTHORIZATION CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
Brand Retinoid S	<p><b>Brand Retinoid Agent(s)</b> will be approved when BOTH of the following are met:</p> <ol style="list-style-type: none"> <li>1. The patient is not using the requested agent for treatment of wrinkles, stretch marks, age spots, or skin lightening <b>AND</b></li> <li>2. The patient has ONE of the following: <ol style="list-style-type: none"> <li>A. The patient is currently being treated with the requested agent and the patient is currently stable on the requested agent [chart notes are required] <b>OR</b></li> <li>B. The request is for a BCBS IL Fully Insured, ASO Cost/BBF, HIM, or Non-ERISA ASO/Self-insured Municipalities/Counties member <b>OR</b></li> <li>C. Tried and had an inadequate response to a generic topical retinoid [chart notes are required] <b>OR</b></li> <li>D. A generic topical retinoid was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event [chart notes are required] <b>OR</b></li> <li>E. An intolerance or hypersensitivity to a generic topical retinoid that is NOT expected to occur with the requested agent [chart notes are required] <b>OR</b></li> <li>F. An FDA labeled contraindication to ALL generic topical retinoids that is NOT expected to occur with the requested agent [chart notes are required] <b>OR</b></li> <li>G. A generic topical retinoid is expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; <b>OR</b> cause a significant barrier to the patient’s adherence of care; <b>OR</b> worsen a comorbid condition; <b>OR</b> decrease the patient’s ability to achieve or maintain reasonable functional ability in performing daily activities; <b>OR</b> cause an adverse reaction or cause physical or mental harm [chart notes are required] <b>OR</b></li> <li>H. A generic topical retinoid is NOT in the best interest of the patient based on medical necessity [chart notes are required] <b>OR</b></li> <li>I. Tried another prescription drug in the same pharmacologic class or with the same mechanism of action as a generic topical retinoid and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event [chart notes are required]</li> </ol> </li> </ol> <p><b>Length of approval:</b></p> <p>BCBSOK: 36 months ALL other plans: 12 months</p> <p><b>The requested agent will also be approved when the following are met:</b></p> <ol style="list-style-type: none"> <li>1. The member resides in Ohio <b>AND</b></li> <li>2. The plan is Fully Insured or HIM Shop (SG) <b>AND</b> BOTH of the following <ol style="list-style-type: none"> <li>A. The patient does NOT have any FDA labeled contraindications to the requested agent <b>AND</b></li> <li>B. ONE of the following: <ol style="list-style-type: none"> <li>1. The patient has another FDA labeled indication for the requested agent and route of administration <b>OR</b></li> </ol> </li> </ol> </li> </ol>

Module	Clinical Criteria for Approval
	<p>2. The patient has another indication that is supported in compendia for the requested agent and route of administration <b>OR</b></p> <p>3. The prescriber has submitted TWO articles from major peer-reviewed professional medical journals [e.g., Journal of American Medical Association (JAMA), New England Journal of Medicine (NEJM), Lancet] supporting the proposed use(s) as generally safe and effective. Accepted study designs may include, but are not limited to, randomized, double blind, placebo controlled clinical trials. NOTE: Case studies are not acceptable [journal articles required]</p> <p><b>Non-oncology compendia allowed:</b> DrugDex level 1, 2A or 2B, AHFS-DI (narrative text must be supportive)</p> <p><b>Oncology compendia allowed:</b> NCCN 1 or 2A, AHFS-DI (narrative text must be supportive), DrugDex level 1, 2A, or 2B, or Clinical Pharmacology (narrative text must be supportive), Lexi-Drugs evidence level A, peer-reviewed medical literature</p> <p><b>Length of Approval:</b></p> <p>BCBSOK: 36 months ALL other plans: 12 months</p>
Generic Retinoid S	<p><b>Generic Retinoid Agent(s)</b> will be approved when the following is met:</p> <p>1. The patient is NOT using the requested agent for treatment of wrinkles, stretch marks, age spots, or skin lightening</p> <p><b>Length of Approval:</b></p> <p>BCBSOK: 36 months ALL other plans: 12 months</p> <p><b>The requested agent will also be approved when the following are met:</b></p> <p>1. The member resides in Ohio <b>AND</b></p> <p>2. The plan is Fully Insured or HIM Shop (SG) <b>AND BOTH</b> of the following</p> <p>A. The patient does NOT have any FDA labeled contraindications to the requested agent <b>AND</b></p> <p>B. ONE of the following:</p> <p>1. The patient has another FDA labeled indication for the requested agent and route of administration <b>OR</b></p> <p>2. The patient has another indication that is supported in compendia for the requested agent and route of administration <b>OR</b></p> <p>3. The prescriber has submitted TWO articles from major peer-reviewed professional medical journals [e.g., Journal of American Medical Association (JAMA), New England Journal of Medicine (NEJM), Lancet] supporting the proposed use(s) as generally safe and effective. Accepted study designs may include, but are not limited to, randomized, double blind, placebo controlled clinical trials. NOTE: Case studies are not acceptable [journal articles required]</p> <p><b>Non-oncology compendia allowed:</b> DrugDex level 1, 2A or 2B, AHFS-DI (narrative text must be supportive)</p>

Module	Clinical Criteria for Approval
	<p><b>Oncology compendia allowed:</b> NCCN 1 or 2A, AHFS-DI (narrative text must be supportive), DrugDex level 1, 2A, or 2B, or Clinical Pharmacology (narrative text must be supportive), Lexi-Drugs evidence level A, peer-reviewed medical literature</p> <p><b>Length of Approval:</b></p> <p>BCBSOK: 36 months ALL other plans: 12 months</p>