Effective Date:11/1/2022
Reviewed: 08/2022, 5/2023, 5/2024, 5/2025, 6/2025, 4/2026 Scope: Medicaid

Tazarotene cream and gel 0.1%

POLICY

I. CRITERIA FOR APPROVAL

An authorization of 12 months may be granted when all the following criteria are met:

A. Patient is 18 years or older and diagnosis of plaque psoriasis; OR
B. The member is age 12 or older and has a diagnosis of acne vulgaris; AND
C. The member has had an adequate trial and failure of two formulary acne vulgaris therapies (e.g., benzoyl peroxide gel, clindamycin/benzoyl peroxide gel, erythromycin gel or solution, tretinoin cream/gel, etc.)

II. QUANTITY LIMIT

- 30 grams per fill and 60 grams per 30 days

III. COVERAGE DURATION

- 12 months

IV. REFERENCES

1. Tazarotene cream 0.1% [prescribing information]. Melville, NY: E Fougera & Co.; March 2025. Accessed April 2026.
2. Tazarotene gel 0.1% [prescribing information]. Irvine, CA: Allergan; November 2023. Accessed April 2026.

Neighborhood Health Plan OF RHODE ISLAND™