Drug Name: Solosec Step Therapy Criteria
Effective Date: 6/7/2019
Last Revision Date: 6/2019, 7/2020, 01/2021, 01/2022, 3/2023, 3/2024

Drug Name:	Solosec (secnidazole)
Required Medical Information:	• Member has failed therapy with at least two formulary alternatives [e.g., Clindamycin phosphate vaginal cream 2%, metronidazole (tablet, vaginal gel 0.75%), tinidazole].
Coverage Duration:	**Initial**: 1 month **Quantity Limit:** single 2-gram packet of granules per treatment

Investigational use: Neighborhood does not provide coverage for drugs when used for investigational purposes. All therapies are considered investigational when used at a dose or for a condition other than those that are recognized as medically accepted indications as defined in any one of the following standard reference compendia: American Hospital Formulary Service Drug information (AHFS-DI), Thomson Micromedex DrugDex, Clinical Pharmacology, Wolters Kluwer Lexi-Drugs, or Peer-reviewed published medical literature indicating that sufficient evidence exists to support use.