

PRIOR AUTHORIZATION CRITERIA

DRUG CLASS	RETINOIDS (TOPICAL)
BRAND NAME (generic)	DIFFERIN (adapalene)
Status: CVS Caremark Criteria Type: Initial Prior Authorization	

POLICY

FDA-APPROVED INDICATIONS

Differin Gel 0.1% and Cream are indicated for the topical treatment of acne vulgaris.
Differin Gel 0.3% and Lotion are indicated for the topical treatment of acne vulgaris in patients 12 years of age and older.

COVERAGE CRITERIA

The requested drug will be covered with prior authorization when the following criteria are met:

- The patient has a diagnosis of acne vulgaris

REFERENCES

1. Differin Cream [package insert]. Fort Worth, TX: Galderma Laboratories, L.P.; November 2011.
2. Differin Gel 0.1% [package insert]. Fort Worth, TX: Galderma Laboratories, L.P.; April 2011.
3. Differin Gel 0.3% [package insert]. Fort Worth, TX: Galderma Laboratories, L.P.; December 2013.
4. Differin Lotion 0.1% [package insert]. Fort Worth, TX: Galderma Laboratories, L.P.; December 2013.
5. Micromedex Solutions [database online]. Greenwood Village, CO: Truven Health Analytics Inc. Updated periodically. www.micromedexsolutions.com [available with subscription]. Accessed June 2017.
6. AHFS DI (Adult and Pediatric) [database online]. Hudson, OH: Lexi-Comp, Inc.; http://online.lexi.com/lco/action/index/dataset/complete_ashp [available with subscription]. Accessed June 2017.
7. Zaenglein A, Pathy A, Schlosser B, et al. Guidelines of Care for Acne Vulgaris Management. *J Am Acad Dermatol.* 2016; 74(5):945-973.