

## Clinical Policy: Topical Tretinoin in Adult Acne Vulgaris

Reference Number: GA.PMN.09

Effective Date: 3/16

Last Review Date: 12/2025

Line of Business: Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### Description

Tretinoin is a topical acne medication that induces differentiation and decreases proliferation of APL cells.

### FDA Approved Indication(s)

Topical tretinoin is indicated for:

- Acne vulgaris
- Fine facial wrinkles
- Mottled facial hyperpigmentation
- Tactile facial roughness

### Policy/Criteria

It is the policy of health plans affiliated with Centene Corporation® that topical tretinoin is **medically necessary** only for adult acne vulgaris when the following criteria are met:

#### I. Initial Approval Criteria

*\*\* Provider must submit documentation (including office chart notes and lab results) supporting that member has met all approval criteria \*\**

##### A. Acne Vulgaris (must meet all):

1. Prescribed by a MD/DO, PA, or NP
2. Member is between the ages of 22 and 40
3. Member has one of the following indications:
  - a) Comedonal (noninflammatory) acne
  - b) Mild papulopustular and mixed (comedonal and papulopustular) acne when used in combination with (i or ii)
    - i. PDL topical Benzoyl Peroxide
    - ii. PDL topical Benzoyl Peroxide with clindamycin or erythromycin
  - c) Moderate to severe papulopustular and mixed (comedonal and papulopustular) acne when used in combination (I or ii)
    - i. Doxycycline, Minocycline, Sarecycline, plus PDL topical Benzoyl Peroxide unless intolerant/contraindicated
    - ii. If contraindicated or intolerant to tetracyclines, member must use Macrolide antibiotic (Azithromycin or Erythromycin)

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(see Section IV: Dosage and Administration section)

4. Request is for a PDL tretinoin product

**Approval duration: 3 months**

**II. Continued Therapy**

**A. Acne Vulgaris** (must meet all):

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member has shown a positive response to therapy
3. If member is on a regimen with antibiotic (oral or topical) therapy, Benzoyl Peroxide is included
4. Member does not have any contraindications to Tretinoin therapy

**Approval duration: 6 months**

**III.: General Information**

Acne vulgaris is the most skin condition that is inflammatory and chronic in nature usually containing comedones (blackheads and whiteheads) and inflammatory lesions (papules, pustules, nodules). Although acne is not physically disabling, it has a psychological impact that can be devastating, leading to low self-esteem, depression, and anxiety. Therefore there is a great demand for effective acne therapies. Medical therapies for acne target one or more of four key factors that promote the development of acne lesions: follicular hyperproliferation and abnormal desquamation, increased sebum production, Propionibacterium acnes proliferation, and inflammation. Topical retinoids are beneficial for both comedonal (noninflammatory) and inflammatory acne making them recommended as initial therapy for most patients. When inflammation is involved antimicrobial therapies (eg, benzoyl peroxide or topical antibiotics) is beneficial. Topical and oral antibiotics are more effective when given in combination with topical retinoids. Moderate to severe inflammatory acne often warrant more aggressive treatment with oral antibiotics. The use of benzoyl peroxide with topical or oral antibiotics decreases the emergence of antibiotic resistant bacteria. Therefore, use of benzoyl peroxide is recommended in patients receiving antibiotic therapy.

**IV. Dosage and Administration (Systemic Antibiotics)**

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Drug Name	Recommended Dosing Regimen	Notes
Doxycycline	<ul style="list-style-type: none"> <li>50-100mg twice daily</li> <li>100mg once daily</li> <li>40mg/day (modified doxycycline)</li> </ul>	
Minocycline Minocycline (Solodyne®) Minocycline (Minolira®)	<ul style="list-style-type: none"> <li>50 or 100mg daily or twice daily or</li> <li>Extended-release 1mg/kg/d up to 135mg/d</li> </ul>	
Sarecycline (Seysara®)	33-54 kg: 60mg once daily 55-84 kg: 100mg once daily 85-136 kg: 150mg once daily	
Tetracycline	250-500mg twice daily	
Azithromycin	500mg 1-3 times per week	
Erythromycin	500mg twice daily	

#### V. Product Availability

Various creams, ointments, gels

#### VI. References

1. Zaenglein AL, Pathy AL, Schlosser BJ, Alikhan A, Baldwin HE, Berson DS, et al. Guidelines of care for the management of acne vulgaris. J Am Acad Dermatol. 2016 Feb 15.
2. Graber E. Acne vulgaris: Overview of management.. In: UpToDate, Post TW (Ed), UpToDate, Waltham, MA. (Accessed on January 21, 2024.)
3. Titus S, Hodge J. Diagnosis and Treatment of Acne. Am Fam Physician. 2012;86(8):734-740
4. Graber E. Acne vulgaris: Management of moderate to severe acne. In: UpToDate, Post TW (Ed), UpToDate, Waltham, MA. (Accessed on January 21, 2024.)

Reviews, Revisions, and Approvals	Date	Approval Date
New policy created	03/16	03/16
Updated tretinoin wording to say “topical tretinoin” including policy name. Updated criteria #2 to say ‘topical Benzoyl Peroxide’.	12/17	
Changed treatment for moderate to severe papulopustular and mixed acne to requiring trial and failure of combination benzoyl peroxide and topical antibiotic (erythromycin or clindamycin). Changed treatment of moderate to severe acne to requiring topical tretinoin to	4/18	4/18

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Reviews, Revisions, and Approvals	Date	Approval Date
be combined with an oral antibiotic (doxycycline or tetracycline at specified doses) and topical benzoyl peroxide		
Annual review. No changes made.	12/18	
Changed current Georgia policy templates to corporate standard templates for drug coverage criteria to meet corporate compliance. Changes/revisions included; new formatting, font size, use of standard policy language for each section of policy, and rearranged order of certain steps in criteria and sections.	2/19	2/19
Annual review. Updated treatment recommendation to add minocycline as option for moderate to severe acne and references. Updated fonts	3/19	4/19
Annual review. No changes	4/2020	4/2020
Annual review. Added sarecycline as a treatment option. Added a Dosage and Administration table. Changed Centene logo to PSHP logo	4/2021	4/2021
2Q 2022 annual review. References reviewed and updated. No other changes made.	4/2022	4/2022
1Q 2023 annual review. No changes made. References reviewed and updated.	1/2023	1/2023
1Q 2024 annual review. No changes made.	1/2024	1/2024
1Q 2025 annual review. Formatting changes made to initial criteria. Added Macrolide antibiotics as therapy options if contraindicated/intolerant to Tetracyclines in initial criteria. Updated Dosage and Administration section to include Macrolide antibiotics. References reviewed and updated. References reviewed and updated.	1/2025	1/2025
4Q 2025 annual review. No changes made.	12/2025	12/2025

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

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The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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**Note: For Medicaid members**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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