

## Texas Prior Authorization Program Clinical Criteria

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### Drug/Drug Class

### Topical Retinoids

This criteria was recommended for review by a MCO to ensure appropriate and safe utilization.

### Clinical Criteria Information included in this Document

- [Drugs requiring prior authorization](#): the list of drugs requiring prior authorization for this clinical criteria
- [Prior authorization criteria logic](#): a description of how the prior authorization request will be evaluated against the clinical criteria rules
- [Logic diagram](#): a visual depiction of the clinical criteria logic
- [Supporting tables](#): a collection of information associated with the steps within the criteria (diagnosis codes, procedure codes, and therapy codes); provided when applicable
- [References](#): clinical publications and sources relevant to this clinical criteria

**Note:** Click the hyperlink to navigate directly to that section.

### Revision Notes

Annual review by staff

Added ICD-10 code L719 to Diagnosis of Rosacea or Actinic Keratosis supporting table

Added GCNs for Differin (29300, 98582), Retin-A (22870, 22882, 22871, 22880, 22881, 17443, 22874, 31776, 36604, 31777), Tazarotene (29222, 85362), and Tretinoin (36604) to the Drugs Requiring PA table

Removed GCN for Avita (22871) and Differin (28403) – products discontinued

Updated references



## Topical Retinoids

### Drugs Requiring Prior Authorization

*The listed GCNs may not be an indication of Texas Medicaid Formulary coverage. To learn the current formulary coverage, visit [txvendordrug.com/searches/formulary-drug-search](http://txvendordrug.com/searches/formulary-drug-search).*

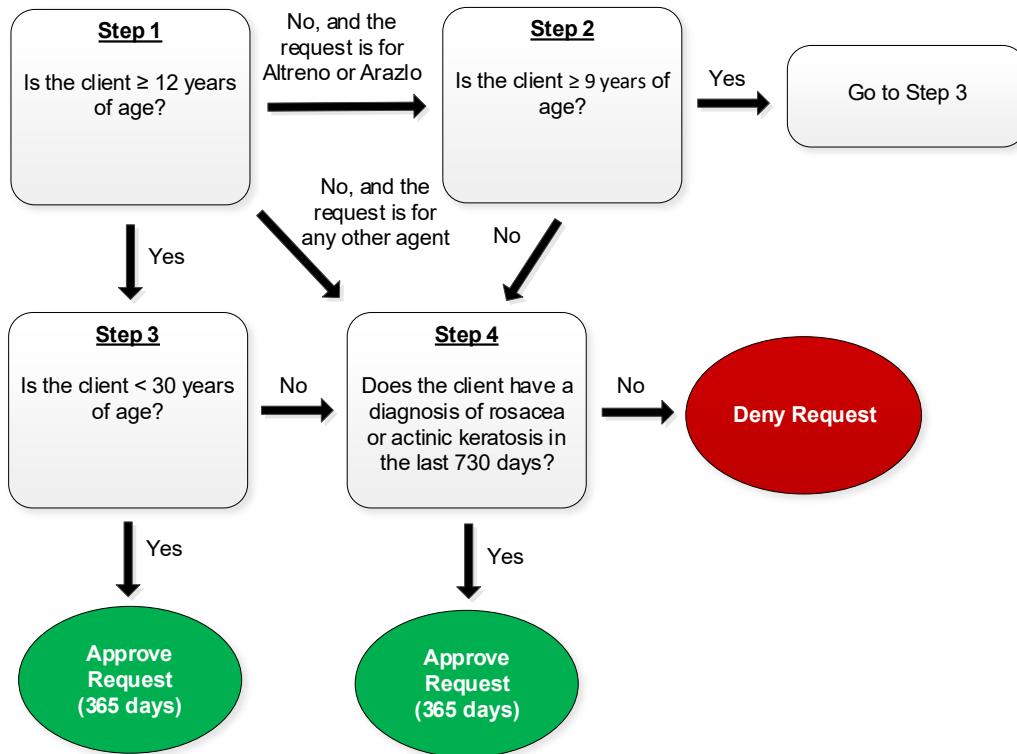
Drugs Requiring Prior Authorization	
Label Name	GCN
ADAPALENE 0.1% CREAM	29301
ADAPALENE 0.1% GEL	29300
ADAPALENE 0.3% GEL	98582
ADAPALENE 0.3% GEL PUMP	31773
ADAPALENE-BENZYL PEROX 0.3-2.5%	39163
ADAPALENE-BENZYL PEROX 0.1-2.5%	31775
AKLIEF 0.005% CREAM	46989
ALTRENO 0.05% LOTION	45194
ARAZLO 0.045% LOTION	47488
ATRALIN 0.05% GEL	22872
AVITA 0.025% CREAM	22882
CLINDA-TRETINOIN 1.2-0.025% GEL	97560
DIFFERIN 0.1% GEL	29300
DIFFERIN 0.1% CREAM	29301
DIFFERIN 0.3% GEL	98582
DIFFERIN 0.3% GEL PUMP	31773
EPIDUO 0.1-2.5% GEL PUMP	31775
EPIDUO FORTE 0.3-2.5% GEL PUMP	39163
FABIOR 0.1% FOAM	32178
RETIN-A 0.01% GEL	22870

Drugs Requiring Prior Authorization	
Label Name	GCN
RETIN-A 0.025% CREAM	22882
RETIN-A 0.025% GEL	22871
RETIN-A 0.05% CREAM	22880
RETIN-A 0.1% CREAM	22881
RETIN-A MICRO 0.04% GEL	17443
RETIN-A MICRO 0.1% GEL	22874
RETIN-A MICRO PUMP 0.04% GEL	31776
RETIN-A MICRO PUMP 0.06% GEL	44075
RETIN-A MICRO PUMP 0.08% GEL	36604
RETIN-A MICRO PUMP 0.1% GEL	31777
TAZAROTENE 0.05% GEL	29221
TAZAROTENE 0.1% GEL	29222
TAZAROTENE 0.05% CREAM	85362
TAZAROTENE 0.1% CREAM	85363
TAZAROTENE 0.1% FOAM	32178
TAZORAC 0.05% CREAM	85362
TAZORAC 0.05% GEL	29221
TAZORAC 0.1% CREAM	85363
TAZORAC 0.1% GEL	29222
TRETINOIN 0.01% GEL	22870
TRETINOIN 0.025% CREAM	22882
TRETINOIN 0.025% GEL	22871
TRETINOIN 0.05% CREAM	22880
TRETINOIN 0.05% GEL	22872

Drugs Requiring Prior Authorization	
Label Name	GCN
TRETINOIN 0.1% CREAM	22881
TRETINOIN GEL MICRO 0.08% PUMP	36604
TRETINOIN GEL MICRO 0.04% PUMP	31776
TRETINOIN GEL MICRO 0.04% TUBE	17443
TRETINOIN GEL MICRO 0.1% PUMP	31777
TRETINOIN GEL MICRO 0.1% TUBE	22874
ZIANA GEL	97560

**Topical Retinoids****Clinical Criteria Logic**

1. Is the client greater than or equal to ( $\geq$ ) 12 years of age?  
[ ] Yes – Go to #3  
[ ] No (And the request is for Altreno or Arazlo) – Go to #2  
[ ] No (And the request is for any other agent) – Go to #4
2. Is the client greater than or equal to ( $\geq$ ) 9 years of age?  
[ ] Yes – Go to #3  
[ ] No – Go to #4
3. Is the client less than ( $<$ ) 30 years of age?  
[ ] Yes – Approve (365 days)  
[ ] No – Go to #4
4. Does the client have a [diagnosis of rosacea or actinic keratosis](#) in the last 730 days?  
[ ] Yes – Approve (365 days)  
[ ] No – Deny

**Topical Retinoids****Clinical Criteria Logic Diagram**



## Topical Retinoids

### Clinical Criteria Supporting Tables

**Table 4 (diagnosis of rosacea or actinic keratosis)****Required quantity: 1****Look back timeframe: 730 days**

ICD-10 Code	Description
L710	PERIORAL DERMATITIS
L711	RHINOPHYMA
L718	OTHER ROSACEA
L719	ROSACEA, UNSPECIFIED
L570	ACTINIC KERATOSIS

**Topical Retinoids****Clinical Criteria References**

1. Clinical Pharmacology [online database]. Tampa, FL: Elsevier/Gold Standard, Inc.; 2025. Available at [www.clinicalpharmacology.com](http://www.clinicalpharmacology.com). Accessed on August 3, 2025.
2. Zaenglein AL, Pathy AL, Schlosser BJ, et al. Guidelines of care for the management of acne vulgaris. *J Am Acad Dermatol*. 2016 Feb 15.
3. Gruber E (2025) Treatment of acne vulgaris. In RP Dellavalle, MS Levy and MV Dahl (Ed), UpToDate. Accessed August 3, 2025.
4. Micromedex [online database]. Available at [www.micromedexsolutions.com](http://www.micromedexsolutions.com). Accessed on August 3, 2025.
5. Reynolds RV, Yeung H, Cheng CE, et al. Guidelines of care for the management of acne vulgaris. *JAAD*;90(5):1006.E31-1006.E30.
6. 2025 ICD-10-CM Diagnosis Codes. 2025. Available at [www.icd10data.com](http://www.icd10data.com). Accessed on August 3, 2025.



## Topical Retinoids

### Publication History

The Publication History records the publication iterations and revisions to this document. Notes for the *most current revision* are also provided in the [Revision Notes](#) on the first page of this document.

Publication Date	Notes
01/26/2018	<ul style="list-style-type: none"><li>Presented to the DUR Board</li></ul>
03/29/2019	<ul style="list-style-type: none"><li>Updated to include formulary statement (The listed GCNS may not be an indication of TX Medicaid Formulary coverage. To learn the current formulary coverage, visit TxVendorDrug.com/formulary/formulary-search.) on each 'Drug Requiring PA' table</li></ul>
07/15/2020	<ul style="list-style-type: none"><li>Added GCNs for Aklief and Altreno to drug table</li></ul>
07/19/2021	<ul style="list-style-type: none"><li>Added GCN for Arazlo (47488) to drug table</li></ul>
11/17/2021	<ul style="list-style-type: none"><li>Annual review by staff</li><li>Updated age for Altreno and Arazlo to 9 years and older</li><li>Updated references</li></ul>
02/23/2024	<ul style="list-style-type: none"><li>Annual review by staff</li><li>Added GCNs for adapalene-bnzyl perox (39163) and tazarotene (29221, 32178)</li><li>Updated references</li></ul>
01/17/2025	<ul style="list-style-type: none"><li>Annual review by staff</li><li>Updated references</li></ul>
08/29/2025	<ul style="list-style-type: none"><li>Annual review by staff</li><li>Added ICD-10 code L719 to Diagnosis of Rosacea or Actinic Keratosis supporting table</li><li>Added GCNs for Differin (29300, 98582), Retin-A (22870, 22882, 22871, 22880, 22881, 17443, 22874, 31776, 36604, 31777), Tazarotene (29222, 85362), and Tretinoin (36604) to the Drugs Requiring PA table</li><li>Removed GCN for Avita (22871) and Differin (28403) – products discontinued</li><li>Updated references</li></ul>