QUANTITY LIMIT PRIOR AUTHORIZATION CRITERIA

BRAND NAME
(generic)

METROCREAM
(metronidazole cream 0.75%)

METROGEL
(metronidazole gel 1%)

METROLOTION
(metronidazole lotion 0.75%)

(metronidazole gel 0.75%)

NORITATE
(metronidazole cream 1%)

Status: CVS Caremark® Criteria
Type: Quantity Limit; Post Limit Prior Authorization

POLICY

FDA-APPROVED INDICATIONS

MetroCream
MetroCream (metronidazole topical cream) Topical Cream is indicated for topical application in the treatment of inflammatory papules and pustules of rosacea.

MetroGel
MetroGel is indicated for the topical treatment of inflammatory lesions of rosacea.

MetroLotion
MetroLotion Topical Lotion is indicated for topical application in the treatment of inflammatory papules and pustules of rosacea.

Metronidazole gel 0.75%
Metronidazole gel is indicated for topical application in the treatment of inflammatory papules and pustules of rosacea.

Noritate
Noritate is indicated for the topical treatment of inflammatory lesions and erythema of rosacea.

INITIAL QUANTITY LIMIT**

INITIAL LIMIT QUANTITY
Limits should accumulate across all drugs and strengths up to highest quantity listed depending on the order the claims are processed. Accumulation does not apply if limit is coded for daily dose.

PLEASE NOTE: Since manufacturer package sizes may vary, it is the discretion of the dispensing pharmacy to fill quantities per package size up to these quantity limits. In such cases the filling limit and day supply may be less than what is indicated.

Drug	1 Month Limit*	3 Month Limit*
MetroCream (metronidazole cream 0.75%)	60 gm / 25 days	180 gm / 75 days
MetroGel (metronidazole gel 1%)	60 gm / 25 days	180 gm / 75 days
MetroLotion (metronidazole lotion 0.75%)	60 mL / 25 days	180 mL / 75 days
(metronidazole gel 0.75%)	60 gm / 25 days	180 gm / 75 days
Noritate (metronidazole cream 1%)	60 gm / 25 days	180 gm / 75 days

**The duration of 25 days is used for a 30-day fill period and 75 days is used for a 90-day fill period to allow time for refill processing.*

**If the patient is requesting more than the initial quantity limit, the claim will reject with a message indicating that a prior authorization is required. The prior authorization criteria would then be applied to requests submitted for evaluation to the PA unit.

COVERAGE CRITERIA

Authorization may be granted for the requested drug when ALL of the following criteria are met:

- The patient has a diagnosis of rosacea
- The requested drug is not being used in a footbath

QUANTITY LIMITS APPLY

120 gm or mL per 25 days* or 360 gm or mL per 75 days*

**The duration of 25 days is used for a 30-day fill period and 75 days is used for a 90-day fill period to allow time for refill processing.*

DURATION OF APPROVAL (DOA)

- 4312-HJ: DOA: 12 months

REFERENCES

1. MetroCream [package insert]. Fort Worth, TX: Galderma Laboratories, L.P; January 2017.
2. MetroGel [package insert]. Dallas, TX: Galderma Laboratories, L.P; November 2023.
3. MetroLotion [package insert]. Fort Worth, TX: Galderma Laboratories, L.P; February 2017.
4. Metronidazole gel 0.75% [package insert]. Mason, OH: Prasco Laboratories; September 2014.
5. Noritate [package insert]. Bridgewater, NJ: Bausch Health US, LLC; June 2020.
6. Lexicomp Online, AHFS DI (Adult and Pediatric) Online. Waltham, MA: UpToDate, Inc.; 2024. https://online.lexi.com. Accessed June 12, 2024.
7. Micromedex® (electronic version). Merative, Ann Arbor, Michigan, USA. Available at: https://www.micromedexsolutions.com/ (cited: 06/12/2024).
8. Eichenfield L, Tom W, Berger T, et al. Guidelines of Care for the Management of Atopic Dermatitis Section 2. Management and Treatment of Atopic Dermatitis with Topical Therapies. *J Am Acad Dermatol* 2014; 71:116-32. https://www.aad.org/practicecenter/quality/clinical-guidelines/atopic-dermatitis. Accessed June 12, 2024.
9. Burn Triage and Treatment - Thermal Injuries. Available at: https://chemm.hhs.gov/burns.htm. Accessed June 12, 2024.