

Clinical Policy: Adapalene/Benzoyl Peroxide (Epiduo Forte)

Reference Number: CP.CPA.337

Effective Date: 12.01.18

Last Review Date: 11.19

Line of Business: Commercial

[Revision Log](#)

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

Description

Adapalene 0.3%/benzoyl peroxide 2.5% (Epiduo[®] Forte) is a topical combination product of two active ingredients: adapalene, a retinoid, and benzoyl peroxide, an oxidizing agent with bactericidal and keratolytic effects.

FDA Approved Indication(s)

Epiduo Forte is indicated for the topical treatment of acne vulgaris.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation[®] that Epiduo Forte is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Acne Vulgaris (must meet all):

1. Diagnosis of acne vulgaris;
2. Age \geq 12 years;
3. Failure of TWO preferred topical anti-acne agents (e.g., topical adapalene, benzoyl peroxide 2.5%/adapalene 0.1%, tretinoin, benzoyl peroxide/erythromycin, clindamycin, benzoyl peroxide/clindamycin phosphate, erythromycin, sulfacetamide/sulfur) unless clinically significant adverse effects are experienced or all are contraindicated;
4. Dose does not exceed 45 g container per month.

Approval duration: Length of Benefit

B. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial.

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 is responding positively to therapy;

3. If request is for a dose increase, dose does not exceed 45 g per month.

Approval duration: Length of Benefit

B. Other diagnoses/indications (must meet 1 or 2):

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.

Approval duration: Duration of request or 12 months (whichever is less); or

2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Topical Retinoids		
adapalene (Differin [®])	Lotion, Cream: 0.1%; Gel: 0.1%, 0.3% Apply topically QD	Not applicable
benzoyl peroxide 2.5%/adapalene 0.1% (Epiduo [®])	Gel: Apply topically QD	Not applicable
tretinoin (Retin-A [®] , Retin-A Micro [®])	Cream: 0.025%, 0.05%, 0.1%; Gel: 0.01%, 0.025%, 0.05%; Microsphere Gel: 0.04%, 0.1% Apply topically QD	Not applicable
Topical Antibiotics		
benzoyl peroxide-erythromycin (Benzamycin [®])	Gel: 5% benzoyl peroxide/3% erythromycin Apply topically QD-BID	Not applicable
clindamycin (Cleocin T [®] , Clindagel [®] , Clindamax [®])	Solution, Gel, Lotion 1%: Apply topically BID Foam 1%: Apply topically QD	Not applicable
benzoyl peroxide/clindamycin phosphate	Duac, Neuac: 1.2% clindamycin/5% benzoyl peroxide: Apply topically QD BenzaClin: 1% clindamycin/5% benzoyl	Not applicable

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
(Duac [®] , Neucac [®] , BenzaClin [®])	peroxide: Apply topically BID	
erythromycin (Erygel [®])	Solution: 2%; Gel: 2% Apply topically BID	Not applicable
sulfacetamide/sulfur	Various strengths Apply topically QD to TID	Not applicable

Therapeutic alternatives are listed as Brand name[®] (generic) when the drug is available by brand name only and generic (Brand name[®]) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings
None reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Acne vulgaris	Apply a pea-sized amount to each affected area of the face and/or trunk topically QD after washing	Not applicable

VI. Product Availability

Gel pump (15 g, 30 g, 45 g, 60 g, 70 g): adapalene 0.3%/benzoyl peroxide 2.5%

VII. References

1. Epiduo Forte Prescribing Information. Fort Worth, TX: Galderma Laboratories; July 2015. Available at: <https://www.epiduoforte.com>. Accessed August 13, 2019.
2. Micromedex[®] Healthcare Series [Internet Database]. Greenwood Village, CO: Truven Health Analytics. Updated periodically. Accessed August 13, 2019.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created: split from previously approved policy CP.CPA.213; no significant changes from previously approved corporate policy; added age; references reviewed and updated.	08.03.18	11.18
4Q 2019 annual review: added max quantity per month; no significant changes; references reviewed and updated.	08.13.19	11.19
Added generic adapalene/benzoyl peroxide 0.1-2.5% gel as an additional option for redirection per June SDC and prior clinical guidance.	06.04.20	

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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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.

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Adapalene/Benzoyl Peroxide



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