UnitedHealthcare Community Plan

Clinical Pharmacy Program Guidelines for Mirvaso

Program	Prior Authorization
Medication	Mirvaso (brimonidine topical gel 0.33%)
Issue Date	5/2014
Pharmacy and Therapeutics Approval Date	11/2017
Effective Date	1/2018

1. Background:

Mirvaso is indicated for the topical treatment of persistent (nontransient) erythema of rosacea in adults 18 years of age or older.

2. Coverage Criteria:

A. Initial Authorization

1. Diagnosis of rosacea

-AND-

2. Patient has moderate to severe persistent (nontransient) facial erythema

Authorization will be issued for 12 months.

B. Reauthorization

1. Documentation of positive clinical response to Mirvaso therapy

Authorization will be issued for 12 months.

3. References:

1. Mirvaso Prescribing Information. Galderma Laboratories, July 2016.
2. Fowler J, Jackson JM, Moore A, et al. Efficacy and safety of once-daily topical brimonidine tartrate gel 0.5% for the treatment of moderate to severe facial erythema of

rosacea: results of two randomized, double-blind, vehicle-controlled pivotal studies. J Drugs Dermatol. 2013; 12(6):650-656.
3. Mirvaso Product Dossier. Galderma Laboratories, September 2013.
4. Oge LK, Muncie HL and Phillips-Savoy AR. Rosacea: Diagnosis and Treatment. *Am Fam Physian*. 2015; 9293):187-196.

Program	Prior Authorization –Mirvaso (brimonidine topical gel 0.33%)
Change Control	
Date	Change
5/2014	New policy
11/2016	Annual review, updated policy template
11/2017	Annual review. Updated references.