

Clinical Policy: Brimonidine Tartrate (Mirvaso)

Reference Number: CP.PMN.192

Effective Date: 06.01.19

Last Review Date: 05.25

Line of Business: Commercial, HIM, Medicaid

[Revision Log](#)

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

Description

Brimonidine tartrate (Mirvaso®) is an alpha-2 adrenergic agonist topical gel. It may reduce erythema through direct vasoconstriction.

FDA Approved Indication(s)

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

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 Mirvaso is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria**A. Facial Erythema Associated with Rosacea (must meet all):**

1. Diagnosis of persistent facial erythema associated with rosacea;
2. Age ≥ 18 years;
3. For brand Mirvaso requests, member must use generic topical brimonidine, unless contraindicated or clinically significant adverse effects are experienced;
4. If papules or pustules are present, failure of, or concomitant treatment with, any of the following agents, unless clinically significant adverse effects are experienced or all are contraindicated: topical metronidazole, oral doxycycline, ivermectin cream, azelaic acid (Finacea®);*

**For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395.*

5. Dose does not exceed 1 tube per month.

Approval duration:**Medicaid/HIM** – 12 months**Commercial** – 12 months or duration of request, whichever is less**B. Other diagnoses/indications (must meet 1 or 2):**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
 - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or

- b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Facial Erythema Associated with Rosacea (must meet all):

1. Member meets one of the following (a or b):
 - a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
 - b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B*);
2. Member is responding positively to therapy;
3. For brand Mirvaso requests, member must use generic topical brimonidine, unless contraindicated or clinically significant adverse effects are experienced;
4. If request is for a dose increase, new dose does not exceed 1 tube per month.

Approval duration:

Medicaid/HIM – 12 months

Commercial - 12 months or duration of request, whichever is less

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

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
 - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
 - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

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 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid, 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
metronidazole (Metrocream [®] 0.75%, Metrogel [®] 1%, Metrolotion [®] 0.75%)	Apply thin film topically to affected area QD for 1% and BID for 0.75%	No maximum dosage information is available.
azelaic acid 15% gel (Finacea [®])	Apply in a thin film topically to the affected area BID Reassess if no improvement in 12 weeks.	No maximum dosage information is available.
doxycycline (Oracea [®])	Lesions (papules and pustules): 40 mg PO once daily in the morning (1 hour before or 2 hours after a meal)	300 mg/day; 40 mg/day for Oracea
ivermectin cream 1% (Soolantra [®])	Apply a pea-size amount to the affected areas of the face (forehead, chin, nose, each cheek) once daily. Spread as a thin layer, avoiding the eyes and lips.	4 oz/topical application

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

- Contraindication(s): hypersensitivity
- Boxed warning(s): none reported

Appendix D: General Information

- Tetracycline agents, including doxycycline and minocycline, exhibit anti-inflammatory activities at doses < 50 mg. Anti-inflammatory dose doxycycline does not exert antibiotic selection pressure and thus does not induce antibiotic resistance; its mechanism of action in rosacea appears to relate to the anti-inflammatory and biological activities of doxycycline.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Facial erythema associated with rosacea	Apply a pea-size amount topically QD to each of the five areas of the face (forehead, chin, nose, each cheek) avoiding the eyes and lips.	One application/day

VI. Product Availability

Gel (30 gm tube or pump, 45 gm tube): 0.33%

VII. References

1. Mirvaso Prescribing Information. Fort Worth, TX: Galderma Laboratories; November 2017. Available at: <https://www.mirvaso.com>. Accessed January 14, 2025.
2. Thiboutot D, Anderson R, Cook-Bolden F, et al. Standard management options for rosacea: the 2019 update by the National Rosacea Society expert committee. *J Am Acad Dermatol*. 2020; 82(6): 1501-1510. doi: 10.1016/j.jaad.2020.01.077.
3. Shaller M, Almeida LMC, Bewley A, et al. Recommendations for rosacea diagnosis, classification and management: update from the global ROSacea COnsensus 2019 panel. *Br J Dermatol*. 2020; 182:1090-1091. doi: 10.1111/bjd.18420.
4. Hampton PJ, Berth-Jones J, Duarte Williamson CE, et al. British Association of Dermatologists' Clinical Standards Unit. British Association of Dermatologists guidelines for the management of people with rosacea 2021. *Br J Dermatol*. 2021 Oct;185(4):725-735. doi: 10.1111/bjd.20485.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
2Q 2021 annual review: added ivermectin 1% cream as an option for failure; references to HIM.PHAR.21 revised to HIM.PA.154; references reviewed and updated.	01.22.21	05.21
2Q 2022 annual review: no significant changes; references reviewed and updated.	01.24.22	05.22
Revised approval duration for Commercial line of business from length of benefit to 12 months or duration of request, whichever is less.	04.27.22	08.22
Template changes applied to other diagnoses/indications and continued therapy section.	10.05.22	
2Q 2023 annual review: no significant changes; references reviewed and updated.	02.07..23	05.23
2Q 2024 annual review: no significant changes; references reviewed and updated.	01.12.24	05.24
2Q 2025 annual review: no significant changes; removed the 30 mg/month max dose restriction; references reviewed and updated. Added step therapy bypass for generic brimonidine for IL HIM per IL HB 5395.	04.24.25	05.25

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Added redirection for brand Mirvaso requests to generic topical brimonidine.	06.12.25	
Added step therapy bypass for brand Mirvaso (previously applied only to generic brimonidine) for IL HIM per IL HB 5395.	07.15.25	

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.

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.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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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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