



## Coverage Policy/Guideline

Name:	Metronidazole topical gel 1% STEP THERAPY	Page:	1 of 1
Effective Date:	10/6/2025	Last Review Date:	9/2025
Applies to:	<input checked="" type="checkbox"/> Arizona		

### Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for metronidazole topical gel 1% under the patient's prescription drug benefit.

### Description:

#### FDA-Approved Indication

Metronidazole topical gel 1% is indicated for the topical treatment of inflammatory lesions of rosacea. Metronidazole topical gel 0.75% is indicated for topical application in the treatment of inflammatory papules and pustules of rosacea. Both the target drug and the pre-requisite drug contain the same active ingredient and can be used for the treatment of rosacea.

### Applicable Drug List:

metronidazole topical gel 1% (generic only)

### Policy/Guideline:

#### Coverage Criteria:

##### Authorization may be granted when the following criteria is met:

- The member has tried and failed a 60 day trial of metronidazole topical gel 0.75% in the last 120 days.

### Approval Duration and Quantity Restrictions:

**Approval:** 12 months

**Quantity Level Limit:** 60 grams per 30 days

### References:

1. Metronidazole Topical Gel 1% [package insert]. Bedminster, NJ: Alembic Pharmaceuticals, Inc. March 2024.
2. Metronidazole Topical Gel 0.75% [package insert]. South Plainfield, NJ: Cosette Pharmaceuticals, Inc. July 2022.
3. Lexicomp Online, AHFS DI (Adult and Pediatric) Online. Waltham, MA: UpToDate, Inc.; 2025. <https://online.lexi.com>. Accessed June 5, 2025.
4. Micromedex® (electronic version). Merative, Ann Arbor, Michigan, USA. Available at: <https://www.micromedexsolutions.com/> (cited: 06/05/2025).