Coverage Policy/Guideline			
Name:	Metronidazole topical gel 1% STEP THERAPY	Page:	1 of 1
Effective Date:	9/2/2025	Last Review Date:	8/13/2025
Applies to:	☒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).