IMIQUIMOD PA SUMMARY

PREFERRED	Aldara 5% cream (PA not required), Zyclara 3.75% cream (PA required)
NON-PREFERRED	Imiquimod 5% cream (PA required)

LENGTH OF AUTHORIZATION: Varies

PA CRITERIA:

Generic Imiquimod 5% cream

- Submit a written letter of medical necessity stating the reason(s) that Aldara is not appropriate for the member.

Zyclara

- Approvable for actinic keratosis (AK) when being used to treat a large area of skin that is greater than 25 cm^2 (5 x 5 cm), such as the full face or scalp. If treating a smaller area, physician must submit a written letter of medical necessity stating the reason(s) that Aldara is not appropriate for the member.
- Approvable for the treatment of external genital and perianal warts (EGW, condylomata acuminata) in members 12 years of age or older. Physician must submit a written letter of medical necessity stating the reason(s) that Aldara is not appropriate for the member.

EXCEPTIONS:

- Exceptions to these conditions of coverage are considered through the prior authorization process.
- The Prior Authorization process may be initiated by calling **SXC Health Solutions at 1-866-525-5827.**

PA and Appeal Process:

- For online access to the PA process please go to www.mmis.georgia.gov/portal, highlight the pharmacy link on the top right side of the page, and click on "prior approval process".

Quantity Level Limitations:

- For online access to the current Quantity Level Limits please go to www.mmis.georgia.gov/portal, highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services Part II and select that manual.