

# Pharmacy Management Drug Policy

<b>SUBJECT: Cosmetic Medications</b> <b>POLICY NUMBER: PHARMACY-146</b> <b>EFFECTIVE DATE: 06/2026</b> <b>LAST REVIEW DATE: 06/01/2026</b>		
<i>If the member's subscriber contract excludes coverage for a specific service or prescription drug, it is not covered under that contract. In such cases, medical or drug policy criteria are not applied. This drug policy applies to the following line/s of business:</i>		
<b>Policy Application</b>		
<b>Category:</b>	<input checked="" type="checkbox"/> Commercial Group (e.g., EPO, HMO, POS, PPO)	<input type="checkbox"/> Medicare Advantage
	<input checked="" type="checkbox"/> On Exchange Qualified Health Plans (QHP)	<input type="checkbox"/> Medicare Part D
	<input checked="" type="checkbox"/> Off Exchange Direct Pay	<input checked="" type="checkbox"/> Essential Plan (EP)
	<input checked="" type="checkbox"/> Medicaid & Health and Recovery Plans (MMC/HARP)	<input checked="" type="checkbox"/> Child Health Plus (CHP)
	<input type="checkbox"/> Federal Employee Program (FEP)	<input type="checkbox"/> Ancillary Services
	<input type="checkbox"/> Dual Eligible Special Needs Plan (D-SNP)	

**DESCRIPTION:**

Cosmetic medications are drugs that are prescribed or requested primarily for the purpose of changing or enhancing physical appearance rather than for the treatment, prevention, or diagnosis of disease. These medications are intended to improve aesthetic characteristics—such as skin texture, hair growth, or visible aging—without producing a meaningful or necessary improvement in physiological function. A medication may be FDA-approved for one or more medical indications but still be classified as cosmetic when used for non-medical, aesthetic purposes. Requests for cosmetic medications are generally based on personal or aesthetic preference and are not considered medically necessary. As such, coverage and authorization decisions for cosmetic medications are subject to specific policy limitations and exclusions outlined in this policy.

**POLICY:**

The Health Plan excludes coverage for cosmetic medications when treatment is not considered medically necessary based on the following criteria:

1. Non-medically necessary cosmetic requests include treatment for aesthetic improvement of non-disabling physical deficits or problems
2. A drug can be considered cosmetic either based on its FDA approved indication, compendia reference or off-label use support.
3. Examples of diagnoses considered cosmetic include (but not limited to); vitiligo, hirsutism, hypotrichosis, hyperpigmentation, alopecia (e.g., areata, androgenic, centrifugal cicatricial), melasma, solar lentigines
4. Unless otherwise specified, cosmetic medications do not become eligible for coverage because of psychiatric and/or emotional distress.

The following list is not all-inclusive, but contains examples of requested medication for diagnoses that are generally considered cosmetic, and as such are not covered except when a case-specific review justifies a medical exception due to a documented functional impairment:

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Brand Name	Generic Name	FDA Indication
Latisse	Bimatoprost 0.003%	Hypertrichosis of the eyelashes
Propecia	Finasteride 1mg	Male pattern baldness or androgenetic alopecia
Renova 0.02% cream	Tretinoin 0.02% topical cream	Reduction of fine lines and wrinkles
Refissa 0.05% cream	Tretinoin (emollient) 0.05% topical cream	Reduction of fine lines and wrinkles
Leqselvi	Deuruxolitinib 8mg	Alopecia areata
Litfulo	Ritlectinib 50mg	Alopecia areata
Mirvaso 0.33% gel	Brimonidine 0.33% topical gel	Facial erythema of rosacea
Rhofade 1% cream	Oxymetazoline 1% topical cream	Facial erythema of rosacea
Pliaglis cream	Lidocaine and tetracaine cream for topical use	Topical local analgesia for superficial dermatologic procedures such as dermal filler injection, pulsed dye laser therapy, facial laser resurfacing and laser-assisted tattoo removal. (These procedures are considered cosmetic).
Tri-Luma Cream	Fluocinolone acetonide 0.01%, hydroquinone 4%, tretinoin 0.05% topical cream	Melasma of the face
Multiple (e.g., Blanche)	Hydroquinone 4% topical cream	Discoloration of skin; Hyperpigmentation of skin
Opzelura cream	Ruxolitinib 1.5% cream	Vitiligo

#### **RELATED POLICES:**

- Corporate Medical Policy 7.01.11 Cosmetic and Reconstructive Procedures
- Botulinum Toxin (Botox, Daxxify, Dysport, Myobloc, Xeomin) Policy (Pharmacy-77)
- Compounded Drugs Policy (Pharmacy-10)
- Inflammatory Conditions Clinical Review Prior Authorization (CRPA) Rx & Medical Drugs Policy (Pharmacy-73)
- Xiaflex (collagenase clostridium histolyticum) Policy (Pharmacy-106)

For criteria specifically related to gender dysphoria refer to the following:

- Gender Dysphoria Policy (Pharmacy-101)

#### **POLICY GUIDELINES:**

1. Utilization Management are contract dependent. Refer to specific contract/benefit language for exclusions.
  - a. Coverage criteria may be dependent on the contract renewal date.
  - b. Coverage of drugs listed in this policy are contract dependent.
  - c. Not all contracts/benefits allow coverage of healthcare professional administered drugs as part of their pharmacy benefit.
  - d. Not all contracts/benefits cover all medical infusible drugs.
2. All utilization management requirements outlined in this policy are compliant with applicable New York State insurance laws and regulations. Policies will be reviewed and updated as necessary to ensure ongoing compliance with all state and federally mandated coverage requirements.
3. This policy is based on available evidence as of the last review date. Coverage determinations are subject to applicable plan documents, state and federal regulations, and individual patient circumstances. This policy does not constitute medical advice.

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4. For commercial contracts, medical necessity determinations align with the Certificate of Coverage issued by the Health Plan, which states that covered services must be clinically appropriate and not primarily for the convenience of the member, the member's family, or the provider.
5. Clinical documentation must be submitted for each request (initial and recertification) unless otherwise specified (e.g., provider attestation required). Supporting documentation includes, but is not limited to, progress notes documenting previous treatments and treatment history, diagnostic testing, laboratory test results, genetic testing or biomarker results, imaging, and other objective or subjective measures of clinical benefit. For recertification, continued approval requires documentation demonstrating that the requested product is providing ongoing benefit to the patient, evidenced by improvement or stability in the disease state or condition, and that continued use remains medically necessary. Ongoing use of the requested product must continue to align with the current policy's preferred formulary. Recertification reviews may result in a requirement to trial more cost-effective treatment alternatives as they become available (e.g., generics, biosimilars, or other guideline-supported treatment options). Requested dosing must remain consistent with FDA-approved or off-label/guideline-supported dosing recommendations.
6. This policy is subject to ongoing revision. Newly marketed drugs and existing drugs with new indications may be subject to prior authorization requirements until formal coverage criteria are established. Inclusion of a drug in this policy does not guarantee its current availability on the market, as some agents may be discontinued, withdrawn, or otherwise unavailable. As product status changes, drugs may be removed from the policy.

### **CODES:**

Eligibility for reimbursement is based upon the benefits set forth in the member's subscriber contract.

**CODES MAY NOT BE COVERED UNDER ALL CIRCUMSTANCES. PLEASE READ THE POLICY AND GUIDELINES STATEMENTS CAREFULLY.**

Codes may not be all inclusive as the AMA and CMS code updates may occur more frequently than policy updates.

Code Key:

Experimental/Investigational = (E/I),

Not medically necessary/ appropriate = (NMN).

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### **HCPCS:**

### **UPDATES:**

Date	Revision
06/01/2026	Created and Implemented
5/14/2026	P&T Committee Approval

### **REFERENCES:**

1. Social Security Act §1862(a)(1)(A). [Social Security Act §1862](#)
2. National Association of Insurance Commissioners (NAIC). *Understanding Medical Necessity*. <https://content.naic.org/sites/default/files/consumer-health-insurance-what-is-medical-necessity.pdf>