

Clinical Policy: Halobetasol Propionate/Tazarotene (Duobrii)

Reference Number: CP.PMN.208

Effective Date: 09.01.19

Last Review Date: 08.25

Line of Business: Commercial, HIM, Medicaid

[Revision Log](#)

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

Description

Duobrii[®] lotion is a combination product containing halobetasol propionate 0.01% and tazarotene 0.045%. Halobetasol propionate is a corticosteroid and tazarotene is a retinoid.

FDA Approved Indication(s)

Duobrii lotion is indicated for the topical treatment of plaque psoriasis (PsO) in adults.

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

I. Initial Approval Criteria**A. Plaque Psoriasis** (must meet all):

1. Diagnosis of PsO with body surface area involvement $\leq 20\%$;
2. Age ≥ 18 years;
3. Prescribed by or in consultation with a dermatologist or rheumatologist;
4. Failure of generic halobetasol propionate and generic clobetasol propionate, unless both are contraindicated or clinically significant adverse effects are experienced;[†]
[†]For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395
5. Failure of generic tazarotene, unless contraindicated or clinically significant adverse effects are experienced;[†]
[†]For Illinois HIM requests, the step therapy requirement above does not apply as of 1/1/2026 per IL HB 5395
6. Dose does not exceed 100 g per month (one tube per month).

Approval duration: 12 months

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. Plaque Psoriasis (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. If request is for a dose increase, new dose does not exceed 100 g per month (one tube per month).

Approval duration: 12 months

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, 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

PsO: plaque psoriasis

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
halobetasol propionate 0.05% cream/ointment (Ultravate [®])	Apply a thin layer to the affected skin QD to BID Treatment should be limited to two weeks.	50 g/week
halobetasol propionate 0.01% lotion (Bryhali [™])	Apply a thin layer to the affected skin once daily. Treatment should be limited to eight weeks.	50 g/week
clobetasol propionate 0.05% cream/foam/gel/ lotion/ointment/shampoo/ spray (Clobex [®] , Olux- E [®] , Olux [®])	Apply a thin layer to the affected skin BID Treatment for mild to moderate plaque psoriasis should be limited to 2 weeks; moderate to severe treatment up to 4 weeks.	50 g/week
tazarotene (Tazorac [®]) cream and gel	Apply a thin layer (2 mg/cm ²) to the affected skin QD Start treatment with 0.05% and increase to 0.1% if tolerated and needed.	2 mg/cm ² /day

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): pregnancy
- Boxed warning(s): none reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Plaque psoriasis	Apply a thin layer of lotion once daily to the affected areas until control is achieved.	50 g/week

VI. Product Availability

Lotion 0.01%/0.045%: 100 g tubes

VII. References

1. Duobrii Prescribing Information. Bridgewater, NJ: Bausch Health Americas, Inc., January 2020. Available at: <https://pi.bauschhealth.com/globalassets/BHC/PI/Duobrii-PI.pdf>. Accessed April 10, 2025.
2. Micromedex® Healthcare Series [Internet database]. Ann Arbor, Michigan: Merative™. Updated periodically. Accessed April 17, 2025.
3. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2025. Available at: <https://www.clinicalkey.com/pharmacology/>. Accessed April 17, 2025.
4. Menter A, Gordon KB, Connor C, et al. National Psoriasis Foundation guidelines of care for the management of psoriasis with systemic nonbiologic therapies. J Am Acad Dermatol. 2020 Feb;02.044.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
3Q 2021 annual review: no significant changes; updated reference for HIM off-label use to HIM.PA.154 (replaces HIM.PHAR.21); references reviewed and updated.	04.02.21	08.21
3Q 2022 annual review: no significant changes; references reviewed and updated.	05.12.22	08.22
Template changes applied to other diagnoses/indications and continued therapy section.	10.05.22	
3Q 2023 annual review: added halobetasol propionate 0.01% lotion as an alternative in Appendix B; references reviewed and updated.	05.01.23	08.23
3Q 2024 annual review: no significant changes; references reviewed and updated.	05.13.24	08.24
3Q 2025 annual review: no significant changes; for Appendix B, updated tazarotene dosing regimen; references reviewed and updated. Added step therapy bypass for IL HIM per IL HB 5395.	06.30.25	08.25

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.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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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