Pharmacy Medical Necessity Guidelines:
Qbrexza™ (glycopyrronium)

Effective: May 12, 2026

Prior Authorization Required	√	Type of Review – Care Management	
Not Covered		Type of Review – Clinical Review	√
Pharmacy (RX) or Medical (MED) Benefit	RX	Department to Review	RXUM
These pharmacy medical necessity guidelines apply to the following: ☒ Tufts Health RITogether – A Rhode Island Medicaid Plan		**Fax Numbers:** RXUM: 617.673.0939	

Note: This guideline does not apply to Medicare Members (includes dual eligible Members).

OVERVIEW

Qbrexza (glycopyrronium) is indicated for topical treatment of primary axillary hyperhidrosis in adult and pediatric patients 9 years of age and older.

COVERAGE GUIDELINES

The plan may authorize coverage of **Qbrexza** when **ALL** of the following criteria are met:

1. The member is at least 9 years of age or older

AND

2. The Member has a documented primary axillary hyperhidrosis

AND

3. The member has had an inadequate response, adverse reaction, or contraindication to an aluminum chloride-containing anti-perspirant

AND

4. **Members 18 years of age and older:** The member has had an inadequate response, adverse, or contraindication to Botox

LIMITATIONS

1. Qbrexza will be limited to a quantity of 30 cloths per month.
2. Documentation of a Member having needle phobia does not qualify as a medically acceptable contraindication or clinical inappropriateness to Botox therapy.

CODES

None

REFERENCES

1. Botox (onabotulinumtoxinA) [prescribing information]. Madison, NJ: Allergan USA, Inc.; August 2022.
2. Doolittle J, Walker P, Mills T et al. Hyperhidrosis: an update on prevalence and severity in the United States. Arch Dermatol Res. 2016; 308(10):743-9.
3. Qbrexza (glycopyrronium) [package insert]. Journey Medical Corporation: Scottsdale, AZ; December 2023.

APPROVAL HISTORY

October 11, 2022: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:

1. August 8, 2023: No changes.
2. May 14, 2024: Effective August 1, 2024, updated RxUM fax number and previous trial language.
3. May 13, 2025: No changes
4. May 12, 2026: No changes.

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical

Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.

Provider Services