RxAdvance

Clinical Policy Title:	alitretinoin
Policy Number:	RxA.452
Drug(s) Applied:	Panretin®
Original Policy Date:	03/06/2020
Last Review Date:	08/28/2024
Line of Business Policy Applies to:	All lines of business (except Medicare)

Criteria

I. **Initial Approval Criteria**

A. **Cutaneous Lesions** (must meet all):
1. Diagnosis of cutaneous lesions associated with AIDS-related Kaposi sarcoma (KS);
2. Member is not receiving systemic anti-KS treatment (e.g., more than 10 new KS lesions in the prior month, symptomatic lymphedema, symptomatic pulmonary KS, or symptomatic visceral involvement).

Approval Duration
All Lines of Business (except Medicare): 12 months

II. **Continued Therapy Approval**

A. **Cutaneous Lesions** (must meet all)**:**
1. Member is currently receiving or has been treated with this medication within the past 120 days, excluding manufacturer samples;
2. Medication is not taken with systemic anti-KS therapy.

Approval Duration:
All Lines of Business (except Medicare): 12 months

References

1. National Comprehensive Cancer Network. AIDS-Related Kaposi Sarcoma Version 1.2024. Available at: https://www.nccn.org/professionals/physician_gls/pdf/kaposi.pdf . Accessed August 28, 2024.

Review/Revision History	Review/Revised Date	P&T Approval Date
Policy established.	01/2020	03/06/2020
Policy was reviewed: 1. Policy title table was updated: Clinical Policy Title was updated to "alitretinoin”. 2. Drug(s) Applied was updated to "Panretin®. 3. Line of Business Policy Applies to was updated to "All”. 4. Clinical policy was updated: Approval duration was updated for both Initial and Continued Approval Criteria; Age criteria was updated to	06/15/2020	09/14/2020

This clinical policy has been developed to authorize, modify, or determine coverage for individuals with similar conditions. Specific care and treatment may vary depending on individual need and benefits covered by the plan. This policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. This document may contain prescription brand name drugs that are trademarks of pharmaceutical manufacturers that are not affiliated with RxAdvance.

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≥ 18 years; Continued Approval was rephrased to "Currently receiving medication that has been authorized by RxAdvance or member has previously met initial approval criteria listed in this policy"; Limit coverage to members without an indication for systemic anti-KS therapy. 5. References were updated.		
Policy was reviewed: 1. Initial Approval Criteria I.A.8 was updated to include "Application does not exceed 4 applications topically per lesion/day". 2. Continued Therapy Approval Criteria II.A.1 was rephrased to "Member is currently receiving medication that has been authorized by RxAdvance...". 3. Continued Therapy Approval Criteria II.A.5 was updated to include "Application does not exceed 4 applications per lesion/day". 4. References were reviewed and updated.	07/14/2021	09/14/2021
Policy was reviewed: 1. Initial Approval Criteria, I.A.4: Updated to remove prior criteria pertaining to indication cutaneous lesions, "There are fewer than 10 new KS lesions in the prior month". 2. Initial Approval Criteria, I.A.4: Updated to include new concurrent therapy criteria Member is not receiving systemic anti-KS treatment (e.g., more than 10 new KS lesions in the prior month, symptomatic lymphedema, symptomatic pulmonary KS, or symptomatic visceral involvement). 3. Initial Approval Criteria, I.A.5: Updated to remove prior criteria pertaining to indication cutaneous lesions, "Member does not have symptomatic lymphedema". 4. Initial Approval Criteria, I.A.6: Updated to remove prior criteria pertaining to indication cutaneous lesions, "Member does not have symptomatic pulmonary KS". 5. Initial Approval Criteria, I.A.7: Updated to remove prior criteria pertaining to indication cutaneous lesions, "Member does not have symptomatic visceral involvement". 6. References were reviewed and updated.	03/30/2022	07/18/2022
Policy was reviewed:	04/27/2023	07/13/2023

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1. Continued Therapy Criteria II.A.3: Updated to remove age criteria. 2. References were reviewed and updated.		
Policy was reviewed.	10/19/2023	10/19/2023
Policy was reviewed: 1. Removed age restrictions. 2. Removed prescriber restrictions. 3. Removed dose restrictions. 4. Updated Continued therapy approval with the new verbiage containing 120 days lookback period. 5. Removed reauthorization requirement for positive response to therapy. 6. Updated approval duration verbiage. 7. References were reviewed and updated.	08/28/2024	09/13/2024

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