UnitedHealthcare Community Plan

Clinical Pharmacy Program Guidelines for Panretin

Program	Prior Authorization
Medication	Panretin® (alitretinoin)
Markets in Scope	Arizona, California, Colorado, Hawaii, Maryland, Nevada, New York, New York EPP, Rhode Island, Pennsylvania- CHIP, New Jersey, South Carolina
Issue Date	9/2013
Pharmacy and Therapeutics Approval Date	11/2020
Effective Date	12/2020

1. Background:

Panretin is indicated for topical treatment of cutaneous lesions in patients with AIDS-related Kaposi's sarcoma (KS). Panretin is not indicated when systemic anti-KS therapy is required (e.g., more than 10 new KS lesions in the prior month, symptomatic lymphedema, symptomatic pulmonary KS, or symptomatic visceral involvement). There is no experience to date using Panretin gel with systemic anti-KS treatment.

2. Coverage Criteria:

A. Kaposi's Sarcoma

1. Diagnosis of AIDS-related Kaposi's Sarcoma (KS)

-AND-

2. Patient is not receiving systemic anti-KS treatment

Authorization will be issued for 12 months.

B. NCCN Recommended Regimens

1. Initial Authorization

a. **Panretin** will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium.

Authorization will be issued for 12 months.

2. Reauthorization

a. **Panretin** will be approved based on the following criterion:

(1) Documentation of positive clinical response to Panretin therapy

Authorization will be issued for 12 months.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place

4. References

1. Panretin Gel [package insert]. Woodcliff Lake, NJ: Eisai Inc., June 2018.

Program	Prior Authorization- Panretin (alitretinoin)
Change Control	
Date	Change
9/19/2013	New guideline.
12/17/2015	Annual Review
11/2016	Removed “in the prior month” from the cutaneous lesions requirement. Updated policy template. Removed extra sections not related to clinical criteria.
11/2017	Minor updates to background.
11/2018	Annual review. Removed prescriber check because other programs do not require this. Added NCCN Recommended Regimen review criteria. Updated references.
11/2019	Annual review. Added reauthorization duration to NCCN section. Updated references.
11/2020	Annual review. Added Additional Clinical Rules section.