UnitedHealthcare Community Plan

Clinical Pharmacy Program Guidelines for Targretin

Program	Prior Authorization
Medication	Targretin® (bexarotene)
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:

Targretin (bexarotene) is a retinoid indicated for the treatment of cutaneous manifestations of cutaneous T-cell lymphoma (CTCL) in patients who are refractory to at least one prior systemic therapy.

Targretin gel 1% is indicated for the topical treatment of cutaneous lesions in patients with CTCL (Stage IA and IB) who have refractory or persistent disease after other therapies or who have not tolerated other therapies.

2. Coverage Criteria:

A. Cutaneous T-Cell Lymphoma

1. Initial Authorization

(a) Diagnosis of cutaneous T-cell lymphoma (CTCL)

-AND-

(b) History of failure, contraindication, or intolerance to at least one prior therapy (including skin-directed therapies [e.g., corticosteroids (clobetasol, diflorasone, halobetasol, augmented betamethasone dipropionate), phototherapy, or systemic therapies [e.g., interferons])

Authorization will be issued for 12 months.

2. Reauthorization

(a) Patient has not had disease progression while on therapy

Authorization will be issued for 12 months.

B. NCCN Recommended Regimens

1. Initial Authorization

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

(1) Documentation of positive clinical response to Targretin 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. Targretin Capsules [package insert]. Bridgewater, NJ: Valeant Pharmaceuticals, LLC; April 2020.
2. Targretin Gel 1% [package insert]. Bridgewater, NJ: Bausch Health Companies Inc.;, February 2020.

Program	Prior Authorization –Targretin (bexarotene)
Change Control	
Date	Change
9/2013	New guideline
12/2015	Annual review; no changes
8/2016	Updated clinical criteria to align with OptumRx except prescriber requirement
11/2017	Updated references and policy template

11/2018	Annual review. Added NCCN Recommended Regimen review criteria. Updated formatting of background. Updated references.
11/2019	Annual review. Updated references.
11/2020	Annual review. Updated references. Added Additional Clinical Rules Section.