PRIOR AUTHORIZATION POLICY

POLICY: Topical Retinoids – Tazarotene Products Prior Authorization Policy
- Arazlo™ (tazarotene 0.045% lotion – Bausch Health)
- Fabior® (tazarotene 0.1% foam – Mayne Pharma, generic)
- Tazorac® (tazarotene 0.05% cream, 0.05% gel, 0.1% cream, and 0.1% gel – Allergan, generics to 0.1% cream, 0.05% gel, and 0.1% gel only)

REVIEW DATE: 08/14/2024

INSTRUCTIONS FOR USE

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. EACH COVERAGE REQUEST SHOULD BE REVIEWED ON ITS OWN MERITS. MEDICAL DIRECTORS ARE EXPECTED TO EXERCISE CLINICAL JUDGMENT AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

CIGNA NATIONAL FORMULARY COVERAGE:

OVERVIEW

Tazorac gel is indicated for the following uses:[1]
- **Plaque psoriasis**, in patients with up to 20% body surface area involvement (0.05% and 0.1% strengths).
- **Facial acne vulgaris,** in patients with mild to moderate severity (0.1% strength only).

Tazorac cream is indicated for the following uses:[2]
- **Plaque psoriasis** (0.05% and 0.1% strengths).
- **Acne vulgaris** (0.1% strength only).

Both Arazlo lotion and Fabior foam are indicated for the topical treatment of **acne vulgaris**.[3,4]

In addition to acne vulgaris and plaque psoriasis, topical tazarotene products have been used to treat other medical skin conditions, such as basal cell carcinoma and

congenital ichthyoses.[5-13] Topical tazarotene products have also been used to treat cosmetic skin conditions such as wrinkles, premature aging, and treatment of photo-aged or photo-damaged skin.

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of topical tazarotene products. All approvals are provided for the duration noted below.

Prior authorization and prescription benefit coverage are not recommended for cosmetic uses.

- **Arazlo™ (tazarotene 0.045% lotion – Bausch Health)**
- **Fabior® (tazarotene 0.1% foam – Mayne Pharma, generic)**
- **Tazorac® (tazarotene 0.05% cream, 0.05% gel, 0.1% cream, and 0.1% gel – Allergan, generics to 0.1% cream, 0.05% gel, and 0.1% gel only)**

is(are) covered as medically necessary when the following criteria is(are) met for FDA-approved indication(s) or other uses with supportive evidence (if applicable):

FDA-Approved Indications

1. **Acne Vulgaris.** Approve for 1 year.

2. **Plaque Psoriasis.** Approve for 1 year.

Other Uses with Supportive Evidence

3. **Treatment of Other Non-Cosmetic Conditions.** Approve for 1 year.
   Note: Examples of other non-cosmetic conditions include: acne keloidalis nuchae, basal cell carcinoma, comedonal acne, cystic acne, cutaneous T-cell lymphoma, ichthyosis (e.g., congenital, lamellar, vulgaris, X-linked), keratoderma blennorrhagicum, keratosis (e.g., keratosis follicularis [Darier's disease], keratosis pilaris), mycosis fungoides, nail psoriasis, oral lichen planus, and warts.

CONDITIONS NOT COVERED

- **Arazlo™ (tazarotene 0.045% lotion – Bausch Health)**
- **Fabior® (tazarotene 0.1% foam – Mayne Pharma, generic)**
- **Tazorac® (tazarotene 0.05% cream, 0.05% gel, 0.1% cream, and 0.1% gel – Allergan, generics to 0.1% cream, 0.05% gel, and 0.1% gel only)**

is(are) considered not medically necessary for ANY other use(s) including the following (this list may not be all inclusive; criteria will be updated as new published data are available):

1. **Cosmetic Conditions.** Cosmetic use is not recommended for coverage as this indication is excluded from coverage in a typical pharmacy benefit.
   Note (this is not an all-inclusive list): Examples of cosmetic conditions include actinic purpura, age spots (also called liver spots, solar lentigines, sun spots), melasma/cholasma, milia, mottled hyperpigmentation, mottled hypopigmentation, photo-aged or photo-damaged skin, pokiloderma (of Civatte), premature aging, scarring, sebaceous hyperplasia, seborrheic keratosis, skin laxity, skin roughness, solar elastosis, solar purpura, stretch marks, and wrinkles.

REFERENCES

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2. Tazorac® cream 0.05%, 0.1% [prescribing information]. Irvine, CA: Allergan; August 2019.
3. Arazlo™ lotion [prescribing information]. Bridgewater, NJ: Bausch Health US; August 2023.
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HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	No criteria changes.	08/02/2023
Annual Revision	No criteria changes.	08/02/2023