PREFERRED SPECIALTY MANAGEMENT POLICY

POLICY: Oncology – Bexarotene (Topical) Preferred Specialty Management Policy
- Targretin® (bexarotene 1% gel – Bausch Health, generic)

REVIEW DATE: 02/07/2024

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

Bexarotene gel is indicated for the topical treatment of cutaneous lesions of **cutaneous T-cell lymphoma** (Stage 1A and 1B) in patients who have refractory or persistent disease after other therapies or who have not tolerated other therapies.[1]

Guidelines

The National Comprehensive Cancer Network (NCCN) Primary Cutaneous Lymphomas guidelines (version 1.2024 – December 21, 2023) recommend topical bexarotene as an option for the treatment of cutaneous lymphomas (e.g., mycosis fungoides, Sézary syndrome, T-cell lymphoma), as initial therapy and for relapsed/refractory cases. NCCN notes there are case reports demonstrating efficacy of topical bexarotene in treating primary cutaneous B-cell lymphomas in children.

POLICY STATEMENT

This Preferred Specialty Management program has been developed to encourage the use of a Preferred Product. For all medications (Preferred and Non-Preferred), the patient is required to meet the respective standard *Prior Authorization Policy* criteria. The program also directs the patient to try one Preferred Product prior to the approval

of a Non-Preferred Product. Requests for Non-Preferred Products will also be reviewed using the exception criteria (below). If the patient meets the standard *Oncology – Bexarotene (Topical) Products Prior Authorization Policy* criteria but has not tried a Preferred Product, approval for a Preferred Product will be authorized. All approvals are provided for 1 year in duration.

Targretin (Brand) Preferred Specialty Management Program
Preferred Product: generic bexarotene gel
Non-Preferred Product: Targretin gel (brand)

Oncology – Bexarotene (Topical) non-preferred product(s) is(are) covered as medically necessary when the following non-preferred product exception criteria is(are) met. Any other exception is considered not medically necessary.

NON-PREFERRED PRODUCT EXCEPTION CRITERIA

Non-Preferred Product	Exception Criteria
Targretin gel	**1.** Approve for 1 year if the patient meets ALL of the following (A, B, and C): **A)** Patient meets the standard *Oncology – Bexarotene (Topical) Prior Authorization Policy* criteria; AND **B)** Patient has tried generic bexarotene gel; AND **C)** Patient cannot continue to use the Preferred medication due to a formulation difference in the inactive ingredient(s) [e.g., difference in buffers, emollients, emulsifiers, preservatives, surfactants] between the brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction. **2.** If the patient has met the standard *Oncology – Bexarotene (Topical) Prior Authorization Policy* criteria (1A), but has not met exception criteria (1B) and/or (1C) above for brand Targretin gel: approve generic bexarotene gel.

REFERENCES

1. Targretin® gel [prescribing information]. Bridgewater, NJ: Bausch Health; February 2020.
2. The NCCN Primary Cutaneous Lymphomas Clinical Practice Guidelines in Oncology (version 1.2024 – December 21, 2023). © 2023 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on February 5, 2024.
3. The NCCN Drugs & Biologics Compendium. © 2024 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on February 5, 2024. Search terms: bexarotene gel.

HISTORY

Type of Revision	Summary of Changes	Review Date
New Policy	Effective date – to be determined	01/25/2023
Annual Revision	No criteria changes.	02/07/2024

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