Premier Health Plan

POLICY AND PROCEDURE

POLICY TITLE: ***Panretin (alitretinoin)***
DEPARTMENT: **Clinical Pharmacy Services- Utilization Management**
ORIGINAL DATE: ***September 2013 (as adopted from UPMC Health Plan)***

Last P & T Committee Approval Date: *February 2018*

Product Applicability: *mark all applicable products below:*

COMMERCIAL	[ ] HMO	[ ] PPO	*Products*: [ ] Small [ ] Indiv. [ ] Large	*Exchange*: [ ] Shop [ ] Indiv.	[x] All
OTHER	[x] Self-funded/ASO				

PURPOSE

The purpose of this policy is to define the prior authorization process for Panretin (alitretinoin).

Panretin (alitretinoin) is indicated for the topical treatment of cutaneous lesions in patients with AIDS-related Kaposi's sarcoma. Alitretinoin is not indicated when systemic anti-Kaposi's sarcoma therapy is required (e.g. more than 10 new lesions in the prior month, symptomatic lymphedema, symptomatic pulmonary Kaposi's sarcoma, or symptomatic visceral involvement).

DEFINITIONS

N/A

POLICY

It is the policy of the Health Plan to maintain a prior authorization process that promotes appropriate utilization of specific drugs with potential for misuse or limited indications. This process involves a review using Food and Drug Administration (FDA) criteria to

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make a determination of Medical Necessity, and approval by the Pharmacy & Therapeutics Committee of the criteria for prior authorization, as described in RX.002 Pharmacy and Therapeutics Committee and RX.003-Prior Authorization Process.

The drug, Panretin (alitretinoin), is subject to the prior authorization process.

PROCEDURE

Initial Authorization Criteria:

Must meet all of the criteria listed below:

- Must be prescribed by or in consultation with a dermatologist or an HIV specialist
- Must be age 18 years or older
- Must have a diagnosis of cutaneous lesions in patients with AIDS-related Kaposi's sarcoma
- Must be on an antiretroviral regimen

Reauthorization Criteria:

All prior authorization renewals are reviewed every 3 months to determine the Medical Necessity for continuation of therapy. Authorization may be extended at 3-month intervals based upon chart documentation from the prescriber that the member's condition has improved based upon the prescriber's assessment while on therapy.

Limitations:

Length of Authorization (if above criteria met)	
Initial Authorization	Up to 3 months
Reauthorization	Up to 3 months

If the established criteria are not met, the request is referred to a Medical Director for review.

REFERENCES

1. Panretin [prescribing information]. Woodcliff Lake, NJ: Eisai, Inc. June 2009.
2. Treatment Options for Kaposi Sarcoma. Bethesda, MD: National Cancer Institution at the National Institutes of Health. Last updated March 25, 2013. Assessed July 31, 2013. Available at: http://www.cancer.gov/cancertopics/pdq/treatment/kaposis/Patient/page9

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RECORD RETENTION

Records Retention for Evolent Health documents, regardless of medium, are provided within the Evolent Health records retention policy and as indicated in CORP.028.E Records Retention Policy and Procedure.

REVIEW HISTORY

DESCRIPTION OF REVIEW / REVISION	DATE APPROVED
Annual review	*02/17, 02/18*

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