PREFERRED SPECIALTY MANAGEMENT POLICY

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

REVIEW DATE: 01/25/2023

OVERVIEW

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

Guidelines

National Comprehensive Cancer Network (NCCN) Primary Cutaneous Lymphomas guidelines (version 1.2023 – January 5, 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.

Automation: None.

Targretin (Brand) Preferred Specialty Management Program

Preferred Product: generic bexarotene gel
Non-Preferred Product: Targretin gel (brand)

RECOMMENDED EXCEPTION CRITERIA

Non-Preferred Product	Exception Criteria
Targretin gel	**1.** Approve for 1 year if the patient meets ALL of the following criteria (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 1.2023 – January 5, 2023). © 2023 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on January 18, 2023.
3. The NCCN Drugs & Biologics Compendium. © 2023 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on January 23, 2023. Search terms: bexarotene gel.