PRIOR AUTHORIZATION POLICY

POLICY: Topical Retinoids – Panretin Prior Authorization Policy

- Panretin® (alitretinoin topical gel – Eisai)

REVIEW DATE: 08/14/2024

OVERVIEW

Panretin, a topical retinoid, is indicated for the topical treatment of cutaneous lesions in patients with Acquired Immunodeficiency Syndrome (AIDS)-related **Kaposi sarcoma**.[1] It is not indicated when systemic anti-Kaposi sarcoma therapy is required (e.g., more than 10 new Kaposi sarcoma lesions in the prior month, symptomatic lymphedema, symptomatic pulmonary Kaposi sarcoma, or symptomatic visceral involvement). Per the prescribing information, there is no experience to date using Panretin gel with systemic anti-Kaposi sarcoma treatment.

Guidelines

Use of Panretin is addressed in the National Comprehensive Cancer Network guidelines for Kaposi sarcoma (version 1.2024 – November 7, 2023).[2] Topical agents are among the first-line therapy recommendations for symptomatic and/or cosmetically unacceptable cutaneous disease; this applies both for patients with human immunodeficiency virus (HIV) and patients without HIV. Panretin is listed as an option for topical treatment (category 2A).

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Panretin. All approvals are provided for the duration noted below. Because of the specialized skills required for evaluation and diagnosis of patients treated with Panretin, approval requires Panretin to be prescribed by or in consultation with a physician who specializes in the condition being treated.

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

Automation: None.

RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Panretin is recommended in those who meet the following criteria:

FDA-Approved Indication

1. **Kaposi Sarcoma.** Approve for 1 year if the patient meets BOTH of the following (A and B):
   - **A)** Patient is not receiving systemic therapy for Kaposi sarcoma; AND
   - **B)** The medication is prescribed by or in consultation with a dermatologist, oncologist, or infectious disease specialist.

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CONDITIONS NOT RECOMMENDED FOR APPROVAL

Coverage of Panretin is not recommended in the following situations:

1. **Cosmetic Uses.** 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, sunspots), 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.

2. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

REFERENCES

1. Panretin® topical gel [prescribing information]. Woodcliff Lake, NJ: Eisai; May 2020.
2. The NCCN Kaposi Sarcoma Clinical Practice Guidelines in Oncology (version 1.2024 – November 7, 2024). © 2023 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on July 25, 2023.

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