Clinical Policy: Bexarotene (Targretin)

Reference Number: CP.PHAR.75
Effective Date: 09.01.11
Last Review Date: 05.18
Line of Business: Commercial, HIM, Medicaid Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Bexarotene (Targretin®) is a retinoid X receptor activator.

FDA Approved Indication(s)

Targretin is indicated for the treatment of cutaneous manifestations of cutaneous T-cell lymphoma (CTCL) in patients who are refractory to at least one prior systemic therapy.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Targretin is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Cutaneous T-Cell Lymphoma (must meet all):

1. Diagnosis of cutaneous T-cell lymphoma (CTCL) (see Appendix C for CTCL subtypes);
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Dose does not exceed 400 mg/m^2/day.

Approval duration:
Medicaid/HIM - 6 months
Commercial - Length of Benefit

B. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Cutaneous T-Cell Lymphoma (must meet all)**:**

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Targretin capsules for CTCL and has received this medication for at least 30 days;
2. Member is responding positively to therapy;

3. If request is for a dose increase, new dose does not exceed 400 mg/m^2/day.

Approval duration:
Medicaid/HIM - 6 months
Commercial - Length of Benefit

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

ALCL: anaplastic large cell lymphoma
ATLL: adult T-cell leukemia/lymphoma
CTCL: cutaneous T-cell lymphoma
FDA: Food and Drug Administration
LyP: lymphomatoid papulosis
MF: mycosis fungoides
NK cells: natural killer cells
RAR: retinoid acid receptor
RXR: retinoic X receptors

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: WHO-EORTC Classification of Cutaneous T-Cell Lymphomas (CTCLs) with Primary Cutaneous Manifestations

- Mycosis fungoides (MF)
- MF variants and subtypes
  - Folliculotropic MF
  - Pagetoid reticulosis
  - Granulomatous slack skin
- Sezary syndrome
- Adult T-cell leukemia/lymphoma (ATLL)
- Primary cutaneous CD30+ lymphoproliferative disorders
  - Primary cutaneous anaplastic large cell lymphoma (ALCL)
  - Lymphomatoid papulosis (LyP)
- Subcutaneous panniculitis-like T-cell lymphoma
- Extranodal NK*/T-cell lymphoma, nasal type

- Primary cutaneous peripheral T-cell lymphoma, unspecified
  - Primary cutaneous aggressive epidermotropic CD8+ T-cell lymphoma
  - Cutaneous gamma/delta T-cell lymphoma
  - Primary cutaneous CD4+ small/medium-sized pleomorphic T-cell lymphoma

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**Extranodal NK-cell lymphoma is considered a CTCL subtype under the policy criteria.*

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
CTCL	300-400 mg/m^2/day PO	400 mg/m^2/day

VI. Product Availability

Capsule: 75 mg

VII. References

1. Targretin (capsules) Prescribing Information. Bridgewater, NJ: Valeant Pharmaceuticals North America LLC; July 2015. Available at http://www.valeant.com/Portals/25/PDF/TargretinCapsules-PI.pdf?ver=2016-05-11-044521-020. Accessed January 2018.
2. Bexarotene. In: National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at www.nccn.org. Accessed January 2018.
3. T-cell lymphomas (Version 2.2018). In: National Comprehensive Cancer Network Guidelines. Available at www.nccn.org. Accessed January 2018.
4. Willemze R, Jaffe ES, Burg G, et al. WHO-EORTC classification for cutaneous lymphomas. *Blood*. May 2005; 105(10): 3768-85.
5. Olsen EA. Evaluation, diagnosis and staging of cutaneous lymphoma. *Dermato Clin.* October 2015; 33(4): 643-54. doi: 10.1016/j.det.2015.06.001.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Removed questions related to pregnancy and contraception Changed the re-auth question about continuing benefits to inquire about disease progression and unacceptable toxicity Updated the clinical background information.	08.13	08.13
Updated clinical background information to include efficacy Added adverse effect leukopenia and monitoring in background Added Appendix A Algorithm: added appendix A	07.14	08.14
Added subheadings and safety information to narrative; added questions regarding age, labs, pregnancy, LFTs, TGLs, and gemfibrozil to algorithm. Reduced approval period to three months as monitoring is required at least every two months.	07.15	07.15
Policy converted to new template. Removed criteria regarding TGL levels, pancreatic risk factors, liver enzymes, bilirubin and concurrent gemfibrozil administration as they are not contraindications or absolute	06.16	07.16

Reviews, Revisions, and Approvals	Date	P&T Approval Date
reason to discontinue per PI. Approval periods, initial/continued, are retained at 3 months/3 months. Subtypes of cutaneous T-cell lymphoma are added at Appendix B, drawing from WHO-EORTC categories presented in Willenze 2005. NCCN compendial uses are added.		
Hypersensitivity precaution and reasons to discontinue removed. Added dosing information. Efficacy statement added to continuation criteria. Approval periods lengthened from 3/3 to 6/12 months.	06.17	07.17
2Q 2018 annual review: Commercial and HIM lines of business added; added age; summarized NCCN and FDA approved uses for improved clarity; added specialist involvement in care; added continuity of care statement; references reviewed and updated.	02.13.18	05.18

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

For Health Insurance Marketplace members, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the formulary exception policy.