PRIOR AUTHORIZATION POLICY

POLICY: Topical Retinoids – Panretin Prior Authorization Policy
- Panretin® (alitretinoin topical gel – Eisai)

REVIEW DATE: 08/13/2025

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 WHERE APPROPRIATE AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. WHERE COVERAGE FOR CARE OR SERVICES DOES NOT DEPEND ON SPECIFIC CIRCUMSTANCES, REIMBURSEMENT WILL ONLY BE PROVIDED IF A REQUESTED SERVICE(S) IS SUBMITTED IN ACCORDANCE WITH THE RELEVANT CRITERIA OUTLINED IN THE APPLICABLE COVERAGE POLICY, INCLUDING COVERED DIAGNOSIS AND/OR PROCEDURE CODE(S). REIMBURSEMENT IS NOT ALLOWED FOR SERVICES WHEN BILLED FOR CONDITIONS OR DIAGNOSES THAT ARE NOT COVERED UNDER THIS COVERAGE POLICY (SEE "CODING INFORMATION" BELOW). WHEN BILLING, PROVIDERS MUST USE THE MOST APPROPRIATE CODES AS OF THE EFFECTIVE DATE OF THE SUBMISSION. CLAIMS SUBMITTED FOR SERVICES THAT ARE NOT ACCOMPANIED BY COVERED CODE(S) UNDER THE APPLICABLE COVERAGE POLICY WILL BE DENIED AS NOT COVERED. 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

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 2.2025 – January 14, 2025).[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.

Prescription benefit coverage is not recommended for cosmetic use.

- **Panretin® (alitretinoin topical gel – Eisai)**

is(are) covered as medically necessary when the following criteria is(are) met for FDA-approved indication(s) or other uses with supportive evidence (if applicable):

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.

CONDITIONS NOT COVERED

- **Panretin® (alitretinoin topical gel – Eisai)**

is(are) considered not medically necessary for ANY other use(s) including the following (this list may not be all inclusive; criteria will be updated as new published data are available):

1. **Cosmetic Use.** 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/chloasma, 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.

REFERENCES

1. Panretin® topical gel [prescribing information]. Woodcliff Lake, NJ: Advanz; December 2024

2. The NCCN Kaposi Sarcoma Clinical Practice Guidelines in Oncology (version 2.2025 – January 13, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on August 1, 2025.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	No criteria changes.	08/02/2023
Annual Revision	No criteria changes.	08/14/2024
Annual Revision	No criteria changes.	08/13/2025

"Cigna Companies" refers to operating subsidiaries of The Cigna Group. All products and services are provided exclusively by or through such operating subsidiaries, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Evernorth Behavioral Health, Inc., Cigna Health Management, Inc., and HMO or service company subsidiaries of The Cigna Group.© 2025 The Cigna Group.