



PREFERRED SPECIALTY MANAGEMENT POLICY

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

REVIEW DATE: 02/11/2026

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

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

Guidelines

Bexarotene gel is discussed in the National Comprehensive Cancer Network (NCCN) guidelines:

- **Cutaneous Lymphomas:** NCCN guidelines (version 1.2026 – December 9, 2025) recommend topical bexarotene as an option for the treatment of cutaneous lymphomas (e.g., mycosis fungoides/Sézary syndrome) as initial therapy and subsequent treatment. Bexarotene gel is also Non-Preferred Product as skin-directed therapy for primary cutaneous B-cell lymphoma

(i.e., marginal zone or follicle center lymphoma) [category 2A]. 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.

Documentation: Documentation will be required where noted in the criteria as **[documentation required]**. Documentation may include, but is not limited to, chart notes, prescription claims records, and prescription receipts.

Targretin (Brand) Preferred Specialty Management Program

Preferred Product: generic bexarotene gel

Non-Preferred Product: Targretin gel (brand)

Oncology – Bexarotene (Topical) Preferred Specialty Management Policy non-preferred product(s) is(are) covered as medically necessary when the following non-preferred product exception criteria is(are) met. Any other exception is considered not medically necessary.

NON-PREFERRED PRODUCT EXCEPTION CRITERIA

Non-Preferred Product	Exception Criteria
Targretin gel	<p>1. Approve for 1 year if the patient meets ALL of the following (A, B, <u>and</u> C):</p> <p>A) Patient meets the standard <i>Oncology – Bexarotene (Topical) Prior Authorization Policy</i> criteria; AND</p> <p>B) Patient has tried generic bexarotene gel [documentation required]; AND</p> <p>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 [documentation required].</p>

	<p>2. If the patient has met the standard <i>Oncology – Bexarotene (Topical) Prior Authorization Policy</i> criteria (1A), but has <u>not</u> met exception criteria (1B) and/or (1C) above for brand Targretin gel: approve generic bexarotene gel.</p>
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REFERENCES

1. Targretin® gel [prescribing information]. Bridgewater, NJ: Bausch Health; February 2020.
2. The NCCN Cutaneous Lymphomas Clinical Practice Guidelines in Oncology (version 1.2026 – December 9, 2025) © 2025 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed on February 9, 2026.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	No criteria changes.	02/07/2024
Annual Revision	Added documentation requirement for trial of generic bexarotene gel and for the exception provided for formulation difference.	02/12/2025
Annual Revision	No criteria changes.	02/11/2026

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