Commercial/Healthcare Exchange PA Criteria

Effective: August 18, 2020

Prior Authorization: Panretin

Products Affected: Panretin (alitretinoin) topical gel

Medication Description: Alitretinoin is a naturally occurring endogenous retinoid that binds to and activates intracellular retinoid receptors (RAR and RXR subtypes); this results in altered expression of the genes controlling cellular differentiation and proliferation in normal and neoplastic cells, inhibiting the growth of Kaposi sarcoma.

Covered Uses: Topical treatment of cutaneous lesions in patients with AIDS-related Kaposi's sarcoma

Exclusion Criteria:

1. When systemic anti-KS therapy is required (e.g., more than 10 new KS lesions in the prior month, symptomatic lymphedema, symptomatic pulmonary KS, or symptomatic visceral involvement).
2. Known hypersensitivity to retinoids

Required Medical Information:

1. Diagnosis

Age Restrictions: 18 years of age and older

Prescriber Restrictions: N/A

Coverage Duration: Initiation: 14 weeks, Continuation: 6 months

A. Effectiveness of use beyond 96 weeks has not been established.

Other Criteria:

Kaposi's Sarcoma

A. Patient has a diagnosis of AIDS-related Kaposi's Sarcoma; AND
B. Panretin is being used for the topical treatment of cutaneous lesions.

References:

1. Panretin Gel [package insert]. Woodcliff Lake, NJ: Eisai Inc., June 2018.

Policy Revision history

Rev #	Type of Change	Summary of Change	Sections Affected	Date
1	New Policy	New Policy	All	8/18/2020