Clinical Policy: Tazarotene (Tazorac)

Reference Number: CP.PMN.75
Effective Date: 11.01.16
Last Review Date: 08.17
Line of Business: Medicaid

Coding Implications
Revision Log

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

Description
Tazarotene cream and gel (Tazorac®) are retinoids. Prior authorization is required for Tazorac for members ≥ 21 years of age.

FDA approved indication
Tazorac cream and gel 0.05% and 0.1% are indicated for the topical treatment of plaque psoriasis.

Tazorac cream and gel 0.1% are also indicated for the topical treatment of acne vulgaris.

Policy/Criteria
Provider must submit documentation (which may include office chart notes and lab results) supporting that member has met all approval criteria

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

I. Initial Approval Criteria

A. Plaque Psoriasis or Acne Vulgaris (must meet all)**:**

1. Diagnosis of one of the following (a or b):
   a. Plaque psoriasis;
   b. Acne vulgaris;
2. At the time of request, member has none of the following contraindications:
   a. Pregnancy;
3. Dose does not exceed 1 package per claim.

Approval duration: 12 months

B. Other diagnoses/indications

1. Refer to CP.PMN.53 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy

A. Plaque Psoriasis or Acne Vulgaris (must meet all)**:**

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed 1 package per claim.

Approval duration: 12 months

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 12 months (whichever is less); or
2. Refer to CP.PMN.53 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

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 policy – CP.PMN.53 or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration

V. Dosage and Administration

Drug	Dosing Regimen	Maximum Dose
Tazorac cream	Apply a thin layer of cream only to the affected area once daily in the evening.	Apply once daily
Tazorac gel	Apply gel once a day, in the evening, to psoriatic lesions, using enough (2 mg/cm2) to cover only the lesion with a thin film to no more than 20% of body surface area. Apply a thin film of gel 0.1% (2 mg/cm2) once a day, in the evening, to the skin where acne lesions appear.	Increase to 0.1% if tolerated and apply once daily

VI. Product Availability

Cream: 0.05% and 0.1%
Gel: 0.05% and 0.1%

VII. Workflow Document

N/A

VIII. References

1. Tazorac Gel Prescribing Information. Irvin, CA: Allergan, Inc., May 2014. Available at http://www.allergan.com. Accessed July 31, 2017.
2. Tazorac Cream Prescribing Information. Irvin, CA: Allergan, Inc., December 2013. Available at http://www.allergan.com. Accessed July 31, 2017.
3. Clinical Pharmacology. Tampa, FL: Gold Standard; 2016. Available at www.clinicalpharmacology.com. Accessed September 23, 2016.

4. Zaenglein AL, Pathy AL, Schlosser BJ et al. Guidelines of care for the management of acne vulgaris. J Am Acad Dermatol. 2016 May;74(5):945-73.e33. doi: 10.1016/j.jaad.2015.12.037.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created.	09.16	11.16
- Updated template and updated references.	08.01.17	11.17

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.