UnitedHealthcare Community Plan

Clinical Pharmacy Program Guidelines for Panretin

Program	Prior Authorization
Medication	Panretin (alitretinoin)
Issue Date	9/2013
Pharmacy and Therapeutics Approval Date	11/2017
Effective Date	1/2018

1. Background:

Drug Name: Panretin (alitretinoin) gel

Indications

AIDS-related Kaposi's sarcoma (KS)
Panretin is indicated for topical treatment of cutaneous lesions in patients with AIDS-related Kaposi's sarcoma (KS). Panretin is not indicated 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). There is no experience to date using Panretin gel with systemic anti-KS treatment.

2. Coverage Criteria:

A. Authorization Criteria

1. Diagnosis of AIDS-related Kaposi's Sarcoma (KS)

-AND-

2. Patient has less than or equal to 10 new cutaneous lesions

-AND-

3. Prescribed by one of the following specialists:
   - Hematologist/Oncologist
   - HIV specialist

Authorization will be issued for 12 months.

3. References

1. Panretin gel Prescribing Information. Eisai Inc., November 2009.
2. National Cancer Institute: Kaposi Sarcoma Treatment (last updated January 21, 2009.) Available at: www.cancer.gov/cancertopics/pdq/treatment/kaposis/HealthProfessional/page6. Accessed February 25, 2009.

Program	Prior Authorization- Panretin (alitretinoin)
Change Control	
Date	Change
9/19/2013	New guideline.
12/17/2015	Annual Review
11/2016	Removed "in the prior month" from the cutaneous lesions requirement. Updated policy template. Removed extra sections not related to clinical criteria.
11/2017	Minor updates to background.