

## **Clinical Policy: Isotretinoin (Claravis, Absorica, Myorisan, Zenatane)**

Reference Number: CP.PMN.143

Effective Date: 12.01.14

Last Review Date: 11.18

[Revision Log](#)

Line of Business: Commercial, HIM\*, Medicaid

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### **Description**

Isotretinoin (Claravis<sup>™</sup>, Absorica<sup>®</sup>, Myorisan<sup>™</sup>, Zenatane<sup>®</sup>) is a retinoid.

*\*For Health Insurance Marketplace (HIM), Absorica is non-formulary and cannot be approved using these criteria; refer to the formulary exception policy, HIM.PA.103.*

### **FDA Approved Indication(s)**

Claravis, Absorica, Myorisan, and Zenatane are indicated for severe recalcitrant nodular acne.

Limitation(s) of use: Claravis, Absorica, Myorisan, and Zenatane may only be administered to patients enrolled in the iPLEDGE program.

### **Policy/Criteria**

*Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.*

It is the policy of health plans affiliated with Centene Corporation<sup>®</sup> that Claravis, Absorica, Myorisan, and Zenatane are **medically necessary** when the following criteria are met:

#### **I. Initial Approval Criteria**

##### **A. Acne (must meet all):**

1. Diagnosis of nodular acne;
2. Age  $\geq$  12 years;
3. Failure of  $\geq$  2 of the following topical agents (must be from 2 different classes listed below), unless contraindicated or clinically significant adverse effects are experienced:
  - a. Topical antibiotics: clindamycin, erythromycin;
  - b. Topical anti-infectives: benzoyl peroxide 10% gel, benzoyl peroxide 10% lotion;
  - c. Topical retinoids: tretinoin 0.025% gel, tretinoin 0.05% cream, tretinoin 0.1% cream;

*\*Prior authorization may be required for tretinoin for age  $\geq$  30 years*
4. At least one of the topical agents above was used concurrently with one of the following oral antibiotics for  $\geq$  60 days: doxycycline, erythromycin, minocycline, tetracycline, trimethoprim-sulfamethoxazole, unless contraindicated or clinically significant adverse effects are experienced to the listed antibiotic agents;
5. If request is for Absorica, member has intolerance or contraindications to the excipients in Claravis, Myorisan, and Zenatane;
6. Dose does not exceed 2 mg/kg/day.

**Approval duration:**

**Medicaid** – 6 months

**HIM** – 6 months for Claravis, Myorisan, and Zenatane (*refer to HIM.PA.103 for Absorica*)

**Commercial** – Length of Benefit

**B. Other diagnoses/indications**

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

**II. Continued Therapy**

**A. Acne (must meet all):**

1. Previously received medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy;
3. If member has received 20 consecutive weeks of treatment, an 8 week treatment-free interval must be allowed prior to reinitiating isotretinoin treatment;
4. If request is for Absorica, member has intolerance or contraindications to the excipients in Claravis, Myorisan, and Zenatane;
5. If request is for a dose increase, new dose does not exceed 2 mg/kg/day.

**Approval duration:**

**Medicaid** – 6 months

**HIM** – 6 months for Claravis, Myorisan, and Zenatane (*refer to HIM.PA.103 for Absorica*)

**Commercial** – Length of Benefit

**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 the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

**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 policies – CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

**IV. Appendices/General Information**

*Appendix A: Abbreviation/Acronym Key*

FDA: Food and Drug Administration

*Appendix B: Therapeutic Alternatives*

*This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.*

<b>Drug Name</b>	<b>Dosing Regimen</b>	<b>Dose Limit/ Maximum Dose</b>
clindamycin 1% (Cleocin T <sup>®</sup> , Clindagel <sup>®</sup> , Clindamax <sup>®</sup> )	Gel, lotion, solution: Apply a thin film twice daily	N/A
erythromycin 2% (Erygel <sup>®</sup> , Klaron <sup>®</sup> )	Gel, solution: Apply to the affected area twice daily	N/A
benzoyl peroxide (Desquam-X <sup>®</sup> ) liquid, gel and lotion	liquid, gel and lotion: Apply once daily to four times daily	N/A
tretinoin (Retin-A <sup>®</sup> )	0.025% gel, 0.05% cream, 0.1% cream: Apply once daily	N/A
doxycycline (Monodox <sup>®</sup> )	50-100 mg orally daily	300 mg per day
erythromycin (EES <sup>®</sup> , Erythromycin Base <sup>®</sup> , Ery-Tab <sup>®</sup> )	250 – 500 mg orally twice daily, followed by twice daily dosing	4 gm per day
minocycline (Minocin <sup>®</sup> , Solodyn <sup>®</sup> )	IR: 100 mg orally twice daily ER: 1 mg/kg orally daily	200 mg per day
tetracycline	125-250 mg orally every 6 hours for 2 weeks, then 125-500 mg orally daily or every other day	4 mg per day
trimethoprim-sulfamethoxazole (Bactrim <sup>®</sup> )	As directed by physician	20 mg/kg/day of trimethoprim

*Therapeutic alternatives are listed as Brand name<sup>®</sup> (generic) when the drug is available by brand name only and generic (Brand name<sup>®</sup>) when the drug is available by both brand and generic.*

*Appendix C: Contraindications*

Not applicable

*Appendix D: General Information*

- Micromedex classifies the use of isotretinoin for the non-FDA labeled indication of acne vulgaris as a Class II-a strength of recommendation.
- The American Academy of Dermatology recognizes that isotretinoin is also useful for the management of lesser degrees of acne that are treatment-resistant or for the management of acne that is producing either physical or psychological scarring.
- Micromedex classifies the use of isotretinoin for the non-FDA labeled indication of rosacea as a Class II-a strength of recommendation.
- The American Acne and Rosacea Society Consensus Recommendations recognize that isotretinoin has been shown to be effective in treating some refractory cases of papulopustular rosacea, but therapeutic benefit may require continued use. Due to the limited data on the management of refractory rosacea, isotretinoin should only be considered in select cases.

- Because of the risk of teratogenicity and to minimize fetal exposure, isotretinoin is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) called iPLEDGE. Isotretinoin must only be prescribed by prescribers who are registered and activated with the iPLEDGE program. Isotretinoin must only be dispensed by a pharmacy registered and activated with iPLEDGE, and must only be dispensed to patients who are registered and meet all the requirements of iPLEDGE. Registered and activated pharmacies must receive isotretinoin only from wholesalers registered with iPLEDGE. For more information call 866-495-0654 or visit <http://www.ipledgeprogram.com>.

**V. Dosage and Administration**

Indication	Dosing Regimen	Maximum Dose
Isotretinoin (Absorica, Claravis, Myorisan, Zenatane)	0.5 to 1 mg/kg/day PO given in two divided doses	2 mg/kg/day

**VI. Product Availability**

Drug Name	Availability
Isotretinoin (Absorica)	Capsules: 10 mg, 20 mg, 25 mg, 30 mg, 35 mg, and 40 mg
Isotretinoin (Claravis, Myorisan, Zenatane)	Capsules: 10 mg, 20 mg, 30 mg, and 40 mg

**VII. References**

- Isotretinoin Clinical Monograph. Clinical Pharmacology. Available at <http://www.clinicalpharmacology-ip.com>. Accessed March 23, 2018.
- Claravis Package Insert. North Wales, PA: Teva Pharmaceuticals USA, Inc.; August 2016. Available at <https://dailymed.nlm.nih.gov/>. Accessed March 23, 2018.
- Zaenglein AL, Pathy AL, Schlosser BJ, Alikhan A, Baldwin HE, Berson DS, et al. Guidelines of care for the management of acne vulgaris. J Am Acad Dermatol. 2016 Feb 15;74(5):945-973.e33. doi: 10.1016/j.jaad.2015.12.037.
- Absorica Package Insert. Jacksonville, FL: Ranbaxy Laboratories, Inc.; September 2015. Available at <http://absorica.com>. Accessed March 23, 2018.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created from CP.PST.06 which was retired. Preferencing added for Claravis, Myorisan, and Zenatane due to better pricing for these agents.	09.05.17	11.17
3Q 2018 annual review: policies combined for Medicaid (CP.PPA.26), HIM (HIM.PA.50) and Commercial (CP.CPA.93) lines of business; no significant changes from previously approved corporate policy; Commercial: added trials of topical and PO medication, changed diagnosis from severe recalcitrant nodular acne to nodular acne; references reviewed and updated.	03.22.18	08.18
Modified approval duration for Medicaid and HIM to 6 months to allow adequate time to achieve the cumulative dose of 120mg/kg-	09.10.18	11.18

Reviews, Revisions, and Approvals	Date	P&T Approval Date
150mg/kg as this cumulative dose is associated with lower rate of relapse and need for retreatment.		

**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.

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**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.

**For Health Insurance Marketplace members**, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the formulary exception policy.

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