Topical Tazarotene

Policy Number: 5.01.570
Origination: 6/2014
Last Review: 7/2018
Next Review: 7/2019

Policy
Blue Cross and Blue Shield of Kansas City (Blue KC) will provide coverage for the topical tazarotene products Tazorac and Fabior when it is determined to be medically necessary because the following criteria are met.

When Policy Topic is covered
Coverage of topical tazarotene products is recommended for those who meet the following criteria:

Food and Drug Administration (FDA)-Approved Indications

1. **Acne Vulgaris.** Approve after a trial with at least one other topical retinoid product (e.g., tretinoin cream/gel/solution/microgel [Avita®, Retin-A®, Retin-A® Micro, generics], adapalene [Differin®]).

   Tazarac is approved for this indication.1-2 Topical retinoids are effective for the treatment of acne, both as initial and maintenance therapy. Treatment algorithms and consensus statements do not differentiate between the topical retinoids but rather refer to them as a therapeutic category.6-9

2. **Plaque Psoriasis (Psoriasis Vulgaris).** Approve.

   Tazorac is indicated for this use.1-2

Other Uses with Supportive Evidence

3. **Treatment of Other Non-Cosmetic Conditions Not Listed Above** (e.g., psoriasis of fingernails or toenails, oral lichen planus, congenital ichthyoses [X-linked recessive ichthyosis, non-erythrodermic autosomal recessive lamellar ichthyosis, autosomal dominant ichthyosis vulgaris], basal cell carcinoma, mycosis fungoides/cutaneous T-cell lymphoma, keratosis pilaris [atrophicans], actinic keratoses, skin neoplasms, warts, dermatitis/eczema, folliculitis, acne rosacea, cystic acne, comedonal acne). Approve.

When Policy Topic is not covered
Coverage of topical tazarotene products are not recommended in the following circumstances:

1. **Cosmetic Conditions** (e.g., alopecia, hyperpigmentation, liver spots, melasma/cholasma, seborrheic keratosis, stretch marks, scarring, wrinkles, premature aging, photo-aged or photo-damaged skin, mottled hyper- and hypopigmentation, benign facial lentigines, roughness, telangiectasia, skin laxity, keratinocytic atypia, melanocytic atypia, dermal elastosis). Cosmetic use is not recommended for coverage as this indication is excluded from coverage in a typical pharmacy benefit.

2. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.
Considerations
Topical tazarotene requires prior authorization through the pharmacy services department.

This Blue Cross and Blue Shield of Kansas City policy statement was developed using available resources such as, but not limited to: Food and Drug Administration (FDA) approvals, Facts and Comparisons, National specialty guidelines, Local medical policies of other health plans, Medicare (CMS), Local providers.

Description of Procedure or Service
Tazarotene is a retinoid prodrug that is converted to an active metabolite which binds selectively to the beta and gamma subtypes of the retinoic acid receptors. Tazorac gel is indicated for the topical treatment of stable plaque psoriasis of up to 20% body surface area (BSA) involvement and for treatment of patients with mild to moderate facial acne vulgaris. Tazorac cream is indicated for treatment of plaque psoriasis and acne vulgaris. The cream formulation is also marketed as Avage which is indicated as an adjunctive agent for the mitigation (palliation) of facial fine wrinkling, facial mottled hyper- and hypo-pigmentation, and benign facial lentigines when a comprehensive skin care and sunlight program is utilized. Fabior foam is indicated for the topical treatment of acne vulgaris in patients ≥ 12 years of age.

In addition to acne vulgaris and plaque psoriasis, topical tazarotene has been used to treat other medical skin conditions, such as basal cell carcinoma and congenital ichthyoses. Topical tazarotene has also been used to treat cosmetic skin conditions such as wrinkles, premature aging, and treatment of photo-aged or photo-damaged skin.

Rationale
References:
1. Tazorac topical gel 0.05%, 0.1% [package insert]. Irvine, CA: Allergan, Inc.; March 2011.
2. Tazorac cream 0.05%, 0.1% [package insert]. Irvine, CA: Allergan, Inc.; February 2011.

Billing Coding/Physician Documentation Information
NA Pharmacy benefit

Additional Policy Key Words
Policy Number: 5.01.570

Policy Implementation/Update Information
06/2014 New Policy titled Topical Tazarotene
07/2015 Annual review – no changes made
07/2016 Annual review – no changes made
State and Federal mandates and health plan contract language, including specific provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The medical policies contained herein are for informational purposes. The medical policies do not constitute medical advice or medical care. Treating health care providers are independent contractors and are neither employees nor agents Blue KC and are solely responsible for diagnosis, treatment and medical advice. No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, photocopying, or otherwise, without permission from Blue KC.