

Clinical Policy: Isotretinoin
Reference Number: CP.CPA.93
Effective Date: 11.16.16
Last Review Date: 08.17
Line of Business: Medicaid – Medi-Cal

Revision Log

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

Description

The following are Isotretinoin agents requiring prior authorization: Isotretinoin (Absorica®), Isotretinoin (Amnesteem®), Isotretinoin (Claravis®), Isotretinoin (Myorisan™) and Isotretinoin (Zenatane™)

FDA approved indication

Absorica® is indicated:

- For the treatment of severe recalcitrant nodular acne in patients 12 years of age and older
- Amnesteem, Claravis, Myorisan and Zenatane are indicated:
- For the treatment of severe recalcitrant nodular acne

Limitation of use: For all agents, may only be administered to patients enrolled in the iPLEDGE program.

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 Absorica, Amnesteem, Claravis, Myorisan and Zenatane are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Severe Recalcitrant Nodular Acne (must meet all):

1. Diagnosis of severe recalcitrant nodular acne;
2. For Absorica requests, failure of ONE of the following unless contraindicated or clinically significant adverse effects are experienced: Amnesteem, Claravis, Myorisan, or Zenatane;
3. Dose does not exceed 2 mg/kg/day.

Approval duration: NATL – Length of benefit; HNAZ – Up to 20 weeks (no processing allowed through mail order)

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. Severe Recalcitrant Nodular Acne (must meet all):

1. Currently receiving medication via health plan benefit or member has previously met initial approval criteria;

2. For requests beyond 20 weeks, patient has had a 2 month break off therapy or total cumulative dose of 150 mg/kg has not been reached;
3. Documentation of persistent or recurring severe nodular acne;
4. Dose does not exceed 2 mg/kg/day for all agents.

Approval duration: Length of benefit

B. Other diagnoses/indications (must meet 1 or 2):

1. Currently receiving medication via health plan 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

- REMS: Risk Evaluation and Mitigation Strategy

Appendix B: General Information

- “Severe” be definition, means “many” as opposed to “few or several” nodules. The nodules may become suppurative or hemorrhagic.
- 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>.

- Isotretinoin may have a negative effect on bone mineral density in some patients. Caution should be used when prescribing isotretinoin to patients with a history of childhood osteoporosis conditions, osteomalacia, or other disorders of bone metabolism. This would include patients diagnosed with anorexia nervosa and those who are on chronic drug therapy that causes drug-induced osteoporosis/osteomalacia and/or affects vitamin D metabolism such as systemic corticosteroids and any anticonvulsant.
- The safety of once daily dosing with isotretinoin has not been established. Once daily dosing is not recommended.

Appendix C: Therapeutic Alternatives

Drug	Dosing Regimen	Dose Limit/Maximum Dose
Topical Retinoids		
adapalene (Differin®)	Cream: 0.1%; Gel: 0.1%, 0.3% Apply topically QD	N/A
tretinoin (Retin-A®)	Cream: 0.025%, 0.05%, 0.1%; Gel: 0.01%, 0.025% Apply topically QD	
tretinoin microsphere (Retin-A Micro®)	Microsphere Gel: 0.04%, 0.1% Apply topically QD	
Tazorac® (tazarotene)	Cream: 0.05%, 0.1%; Gel: 0.05%, 0.1% Apply topically QD	
Topical Antibiotics		
benzoyl peroxide-erythromycin (Benzamycin®)	Gel: 5% benzoyl peroxide/3% erythromycin Apply topically QD-BID	N/A
clindamycin (Cleocin T®, Clindagel®, Clindamax®)	Solution, Gel, Lotion, Foam: 1%: Solution, Gel, Lotion: Apply topically BID Foam: Apply topically QD	
benzoyl peroxide-clindamycin phosphate (Duac®, Neuac®), Benzaclin	Duac®), Neuac: 1.2% clindamycin /5% benzoyl peroxide Apply topically to affected area QD BenzaClin: 1% clindamycin/5% benzoyl peroxide Apply topically BID	
erythromycin (Erygel®)	Solution: 2%; Gel: 2% Apply topically BID	
sulfacetamide /sulfur	Various strengths Apply topically QD to TID	

Drug	Dosing Regimen	Dose Limit/Maximum Dose
Oral Antibiotics		
tetracycline	Varies: 125-250 mg PO Q6H for 2 wks, then decrease to 125-500 mg PO QD or QOD	4 gm/day
erythromycin (EES [®] , Erythromycin Base, Ery-Tab [®] ,)	250-500 mg PO BID initially, followed by 250 to 500 mg PO QD for maintenance	4 gm/day
minocycline (Minocin [®] , Solodyn)	IR: 100 mg PO BID ER: 1 mg/kg PO QD	200 mg/day
doxycycline (Monodox [®])	50-100 PO mg PO QD	300 mg/day

V. Dosage and Administration

Absorica, Amnesteem, Claravais, Myorisan, Zenatane						
Indication	Dosing Regimen					Maximum Dose
Severe Recalcitrant Nodular Acne	0.5-1 mg/kg/day PO divided into 2 doses					2 mg/kg/day
	Body Weight		Daily Dose			
	Kg.	Lbs.	0.5 mg/kg/day	1 mg/kg/day	2 mg/kg/day	
	40	88	20	40	80	
	50	110	25	50	100	
	60	132	30	60	120	
	70	154	35	70	140	
	80	176	40	80	160	
	90	198	45	90	180	
	100	220	50	100	200	

VI. Product Availability

Drug	Availability
Absorica [®]	Capsule: 10 mg, 20 mg, 25 mg, 30 mg, 35 mg and 40 mg
Amnesteem [®]	Capsule: 10 mg, 20 mg and 40 mg
Claravis [®]	Capsule: 10 mg, 20 mg, 30 mg and 40 mg
Myorisan [™]	Capsule: 10 mg, 20 mg, 30 mg and 40 mg
Zenatane [™]	Capsule: 10 mg, 20 mg, 30 mg and 40 mg

VII. References

1. Absorica [Prescribing Information] Jacksonville, FL: Ranbaxy Laboratories Inc.; September 2015.
2. Amnesteem [Prescribing information] Morgantown, WV: Mylan Pharmaceuticals Inc.; March 2015.
3. Claravis [Prescribing information] North Wales, PA: Teva Pharmaceuticals USA, Inc.; April 2016.
4. Myorisan [Prescribing Information] Lake Forest, IL: VersaPharm Inc.; September 2015.
5. Zenatane [Prescribing Information] Bachupally, India: Dr. Reddy's Laboratories Limited; June 2015.
6. 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.
7. Goldsmith LA, Bolognia JL, Callen JP, et al. American Academy of Dermatology Consensus Conference on the safe and optimal use of isotretinoin: summary and recommendations. J Am Acad Dermatol 2004; 50:900-906.
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9. Del Rosso JQ, Thiboutot D, Gallo R, et al. Consensus recommendations from the American Acne & Rosacea Society on the management of rosacea, Part 3: A status report on systemic therapies. Cutis 2014; 93:18-28.
10. Isotretinoin. American Hospital Formulary Service Drug Information. Available at <http://www.medicinescomplete.com/mc/ahfs/current>. Accessed January 12, 2017.
11. Micromedex® Healthcare Series [Internet Database]. Greenwood Village, Colo: Thompson Healthcare. Updated periodically. Accessed January 12, 2017.
12. Clinical Pharmacology Web Site. Available at: <http://www.clinicalpharmacology-ip.com/default.aspx>. Accessed January 12, 2017.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Converted to new template; minor changes to verbiage and grammar. References updated.	01.12.17	8.17

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.

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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.

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