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| --- | --- | --- | --- |
| **Criteria Title** | Topical Retinoid | | |
| **Criteria Subtitle** | Panretin (alitretinoin) | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred |  | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code(s) | Type of Code (GCNSeqNo, HICL, NDC) |
| PANRETIN | 041643 | GCNSeqNo |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 1233 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1234 |
| N | 1235 |
| 2 | 1234 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | END (Approve x 90 days) |
| Continuation (re-authorization request) | END (Approve x 365 days) |
| 3 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: Initial authorizations will be for 90 days; Re-Authorization requests 365 days.

|  |  |
| --- | --- |
| **Last Approved** | 5/1/2023 |
| **Other** |  |