|  |  |  |  |
| --- | --- | --- | --- |
| **Criteria Title** | Retinoid X Receptor Activator | | |
| **Criteria Subtitle** | Targretin (bexarotene) | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred |  | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code(s) | Type of Code (GCNSeqNo, HICL, NDC) |
| TARGRETIN | 045771 | GCNSeqNo |
| TARGRETIN | 044269 | GCNSeqNo |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 1000 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1001 |
| N | 1235 |
| 2 | 1001 |  | Select | Is the medication being prescribed by an oncologist? | Y | 1002 |
| N | 1235 |
| 3 | 1002 |  | Select | Which medication is being requested? | Targretin (bexarotene) Capsules | 1003 |
| Targretin (bexarotene) Gel | 2000 |
| Other | 1235 |
| 4 | 1003 |  | Select and Free Text | Has the patient had an inadequate clinical response to at least one prior systemic therapy?  If yes, please provide documentation. | Y | 1004 |
| N | 1235 |
| 5 | 1004 |  | Select and Free Text | Has the provider submitted documentation of the patient’s baseline complete blood count (CBC), fasting lipid profile, liver function tests, and thyroid profile prior to initiation of therapy?  If yes, please provide documentation. | Y | END (Pending Manual Review) |
| N | 1235 |
| 6 | 2000 |  | Select and Free Text | Has the patient had an inadequate clinical response to at least 3 of the following:   1. Local radiation 2. Phototherapy 3. Topical carmustine 4. Topical corticosteroids 5. Topical imiquimod 6. Topical mechlorethamine (mustard)   If yes, please provide documentation. | Y | END (Pending Manual Review) |
| N | 1235 |
| 7 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 Days

|  |  |
| --- | --- |
| **Last Approved** | 4/10/2023 |
| **Other** |  |