TITLE:  Topical Tretinoin (AVITA®, RENOVA®, RETIN-A®, RETIN-A MICRO®, VESANOID®, TRETIN-X®, ATRALIN, REFISSA®)

EFFECTIVE DATE: August 1, 2015

DOCUMENT HISTORY
Original Endorsement Date: 11/7/13
Subsequent Endorsement Date(s): 4/15/15

This policy was developed and approved by the Medica Pharmacy and Therapeutics Committee.

Important Information – Please Read Before Using This Policy

These services may or may not be covered by all Medica plans. Please refer to the member’s plan document for specific coverage information. If there is a difference between this general information and the member’s plan document, the member’s plan document will be used to determine coverage. With respect to Medicare, Medicaid and MinnesotaCare members, this policy will apply unless these programs require different coverage. Members may contact Medica Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions about this Medica coverage policy may call the Medica Provider Service Center toll-free at 1-800-458-5512.

Medica utilization management policies are not medical advice. Members should consult with appropriate health care providers to obtain needed medical advice, care and treatment.

PURPOSE

To promote consistency between reviewers in utilization management decision-making by providing the criteria that generally determines the medical necessity of tretinoin (Avita®, Renova®, Retin-A®, Retin-A micro®, Vesanoid®, Tretin-X®, Atralin®, Refissa®). The Coverage issues box below outlines the process for addressing the needs of individuals who do not meet these criteria.

MEDICAL NECESSITY CRITERIA

I. Indications for topical formulation
   a. Acne vulgaris
   b. Precancerous lesions
   c. Skin cancers
   d. Pseudofolliculitis barbae
   e. Molluscum contagiosum
   f. Flat warts
   g. Psoriasis
   h. Darier’s disease (keratosis follicularis)
   i. Keloids
   j. Lichen planus
   k. Ichthyosis vulgaris
   l. Ichthyosis congenita
   m. Dermatitis
   n. Folliculitis
   o. Geographic tongue

Note: Tretinoin is not approvable for conditions deemed cosmetic in nature.

II. Written documentation from the medical record must include:
   a. Diagnosis of one of the above conditions listed under section I.
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<th>COVERAGE ISSUES</th>
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<tr>
<td>1. Coverage may vary according to the terms of the member’s coverage document.</td>
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<td>2. When submitting a request for clinical review, Medica must receive a completed <em>General Prior Authorization Form</em>. Complete all fields and fax the form to the MedImpact Prior Authorization Department at 1-858-790-7100 or call 1-800-788-2949.</td>
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<td>3. If the Medical Necessity and Coverage Criteria are met, Medica will authorize benefits within the limits in the member’s coverage document.</td>
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<td>4. If it appears that the Medical Necessity and Coverage Criteria are not met, the individual’s case will be reviewed by the medical director or an external reviewer. Practitioners are advised of the appeal process in their Medica administrative handbook.</td>
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References: