TOPOICAL RETINOID PRODUCTS
(adapalene, tretinoin and combination products)
Pharmacy Coverage Policy

P & T Reviewed Date: 08/26/2015
UMC Revision Date: 07/30/2015
Reviewer Initials: AJB
Effective Date: 09/15/2015
Policy type: PA
Program type: Standard
Specialty: No
Line of Business: Commercial

<table>
<thead>
<tr>
<th>Brand Name</th>
<th>Generic Name</th>
<th>GPI</th>
<th>Drug Class</th>
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<tbody>
<tr>
<td>ATRALIN</td>
<td>tretinoin</td>
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<td>Acne products</td>
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<td>AVITA</td>
<td>adapalene</td>
<td>90050003******</td>
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<td>DIFFERIN</td>
<td>adapalene/benzoyl peroxide</td>
<td>9005990203****</td>
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<td>EPIDUO</td>
<td>tretinoin microsphere</td>
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<tr>
<td>EPIDUO FORTE</td>
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<td>ZIANA</td>
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CRITERIA FOR COVERAGE/NONCOVERAGE

Topical retinoids are covered without prior authorization for patients under the age of 26 years. Topical retinoids will be considered for coverage under the pharmacy benefit program for patients 26 years of age and older when the following criteria are met:

Veltin and Ziana only
- Patient does not have any of the following contraindications:
  - Regional enteritis
  - Ulcerative colitis
  - History of antibiotic-associated colitis

All Topical Retinoids
- Patient has one of the following diagnoses:
  - Acne vulgaris
  - Actinic keratoses (or solar keratosis) with multiple lesions on the face
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- Epidermolytic hyperkeratosis
- Lenticularis perstans (Flegel’s disease)
- Palmoplantar hyperatosis
- Keratosis follicularis (Darier’s disease)
- Ichthyosis (i.e. congenital, lamellar, vulgaris, or X-linked)

Authorization Duration
Authorization for continued use shall be reviewed at least every 12 months to confirm the following:
- Current coverage policy criteria are met and the medication is effective.

Topical retinoid products are considered experimental/investigational for conditions not listed in this coverage policy section.