

## **Clinical Policy: Tazarotene (Arazlo, Fabior, Tazorac)**

Reference Number: CP.PMN.244

Effective Date: 09.01.20

Last Review Date: 11.23

Line of Business: Commercial, HIM, Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### **Description**

Tazarotene lotion (Arazlo<sup>®</sup>), foam (Fabior<sup>®</sup>), cream and gel (Tazorac<sup>®</sup>) are topical retinoids.

### **FDA Approved Indication(s)**

Tazarotene is indicated for the topical treatment of:

- Plaque psoriasis (*Tazorac cream and gel 0.05% and 0.1%*)
- Acne vulgaris:
  - That is facial and of mild to moderate severity (*Tazorac cream and gel 0.1%*)
  - In patients 9 years of age and older (*Arazlo lotion*)
  - In patients 12 years of age or older (*Fabior foam*)

Limitation(s) of use: The safety of Tazorac gel use on more than 20% body surface area has not been established.

### **Policy/Criteria**

*Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.*

It is the policy of health plans affiliated with Centene Corporation<sup>®</sup> that Arazlo, Fabior, and Tazorac are **medically necessary** when the following criteria are met:

#### **I. Initial Approval Criteria**

##### **A. Plaque Psoriasis (must meet all):**

1. Request is for tazarotene cream or gel;
2. Diagnosis of plaque psoriasis with body surface area involvement of  $\leq 20\%$ ;
3. Request does not exceed 1 tube per month.

**Approval duration: 12 months**

##### **B. Acne Vulgaris (must meet all):**

1. Diagnosis of acne vulgaris;
2. For Arazlo and Fabior requests only, member meets all of the following (a, b, and c):
  - a. Member meets one of the following (i or ii):
    - i. For Arazlo: age  $\geq 9$  years;
    - ii. For Fabior: age  $\geq 12$  years;
  - b. Member must use generic formulary topical tazarotene;

- c. Failure of generic formulary topical tretinoin\* and adapalene, unless clinically significant adverse effects are experienced or both are contraindicated;  
*\*Prior authorization may be required for tretinoin*
3. Request does not exceed 1 tube (Arazlo, Tazorac) or 1 can (Fabior) per month.

**Approval duration: 12 months**

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

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
  - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
  - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

**II. Continued Therapy**

**A. All Indications in Section I (must meet all):**

1. Member meets one of the following (a or b):
  - a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
  - b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B*);
2. Member is responding positively to therapy;
3. If request is for a dose increase, new request does not exceed 1 tube (Arazlo, Tazorac) or 1 can (Fabior) per month.

**Approval duration: 12 months**

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

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
  - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or

- b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

**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 policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid, or evidence of coverage documents.

**IV. Appendices/General Information**

*Appendix A: Abbreviation/Acronym Key*

FDA: Food and Drug Administration

*Appendix B: Therapeutic Alternatives*

*This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.*

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
tretinoin (Retin-A <sup>®</sup> )	<b>Acne Vulgaris</b> 0.025% gel, 0.05% cream, 0.1% cream: Apply once daily	Not applicable
adapalene (Differin <sup>®</sup> )	<b>Acne Vulgaris</b> Lotion, Cream: 0.1%; Gel: 0.1%, 0.3% Apply topically QD	Not applicable

*Therapeutic alternatives are listed as Brand name<sup>®</sup> (generic) when the drug is available by brand name only and generic (Brand name<sup>®</sup>) when the drug is available by both brand and generic.*

*Appendix C: Contraindications/Boxed Warnings*

- Contraindication(s):
  - Pregnancy
  - Tazorac: Individuals who have known hypersensitivity to any of its components
- Boxed warning(s): none reported

**V. Dosage and Administration**

Drug Name	Indication	Dosing Regimen	Maximum Dose
Tazarotene (Tazorac) cream and	Plaque psoriasis	Apply gel or cream, 0.05% with strength increased to 0.1% if tolerated and medically indicated, qPM to psoriatic	2 mg/cm <sup>2</sup> /day

Drug Name	Indication	Dosing Regimen	Maximum Dose
gel 0.05% and 0.1%		lesions, using enough (2 mg/cm <sup>2</sup> ) to cover only the lesion with a thin film.  <i>*Do not cover more than 20% of body surface area with the gel formulation.</i>	
Tazarotene (Tazorac) cream and gel 0.1%	Acne	Apply a thin film (2 mg/cm <sup>2</sup> ) of gel or cream 0.1% qPM, to the skin where acne lesions appear.	2 mg/cm <sup>2</sup> /day
Tazarotene (Arazlo) lotion 0.045%	Acne	Apply a thin layer to the affected areas once daily. Avoid the eyes, mouth, paranasal creases and mucous membranes. Not for oral, ophthalmic or intravaginal use.	Once daily application
Tazarotene (Fabior) foam 0.1%	Acne	Apply a thin layer to the entire affected areas of the face and/or upper trunk once daily in the evening. Avoid the eyes, lips, and mucous membranes.	Once daily application

#### VI. Product Availability

Drug Name	Availability
Tazarotene (Tazorac)	Cream (30 g and 60 g tube): 0.05%, 0.1% ( <i>generic available</i> ) Gel (30 g and 100 g tube): 0.05%, 0.1%
Tazarotene (Arazlo)	Lotion (45 g tube): 0.045%
Tazarotene (Fabior)	Foam (50 g and 100 g can): 0.1%

#### VII. References

1. Arazlo Prescribing Information. Bridgewater, NJ: Bausch Health US LLC, May 2021. Available at: <https://pi.bauschhealth.com/globalassets/BHC/PI/arazlo-pi.pdf>. Accessed August 2, 2023.
2. Fabior Prescribing Information. Greenville, NC: Mayne Pharmaceuticals, June 2018. Available at: <https://www.dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=ae0afed7-1d60-45fd-a08b-8db094618521>. Accessed August 2, 2023.
3. Tazorac Cream Prescribing Information. Irvine, CA: Allergan, Inc., August 2019. Available at: [https://almiralladvantage.com/wp-content/uploads/2023/02/Tazorac\\_Cream\\_USPI\\_final\\_Aug2019.pdf](https://almiralladvantage.com/wp-content/uploads/2023/02/Tazorac_Cream_USPI_final_Aug2019.pdf). Accessed August 2, 2023.
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5. Clinical Pharmacology. [database online]. Tampa, FL: Gold Standard, Inc.; 2023. Available at: <https://www.clinicalkey.com/pharmacology/>. Accessed August 2, 2023.
6. Zaenglein AL, Pathy AL, Schlosser BJ et al. Guidelines of care for the management of acne vulgaris. J Am Acad Dermatol. 2016 May;74(5):945-73.e33. doi:10.1016/j.jaad.2015.12.037.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created. Retire CP.PMN.75 Age Limit for Tazarotene (Tazorac, Arazlo); Fabior was added to the policy, in order to allow for SDC-requested redirection to generic preferred products for the treatment of acne vulgaris without limiting the redirection only to members < 21 years of age.	05.28.20	08.20
4Q 2020 annual review: removed requirement for dermatologist for plaque psoriasis indication; references reviewed and updated.	08.06.20	11.20
4Q 2021 annual review: no significant changes; updated reference for HIM off-label use to HIM.PA.154 (replaces HIM.PHAR.21); references reviewed and updated.	08.09.21	11.21
4Q 2022 annual review: no significant changes; for acne vulgaris converted “Documentation supports inability to use” to “Member must use” language; references reviewed and updated. Template changes applied to other diagnoses/indications and continued therapy section.	08.15.22	11.22
4Q 2023 annual review: no significant changes; references reviewed and updated.	08.02.23	11.23
In initial approval criteria, added clarification stating prior authorization may be required for tretinoin.	02.13.24	

**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

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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.

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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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