Clinical Oversight Review Board (CORB) Criteria for Prescribing

Bexarotene 1% gel (Targretin)

Non-Formulary **bexarotene 1% gel (Targretin (Brand)** requires a clinical review. Appropriateness of therapy will be based on the following criteria:

Initiation (new start) criteria: Non-formulary **bexarotene 1% gel (Targretin (Brand)** will be covered on the prescription drug benefit when the following criteria are met:

- Prescriber is a Dermatologist or Oncologist
- Diagnosis of cutaneous T-cell lymphoma (CTCL), stage IA or IB
- Inadequate response, or relative contraindication to alternative CTCL treatment regimens:
  - Topical corticosteroids
  - Topical imiquimod
  - Topical tazarotene
  - Topical mechlorethamine (nitrogen mustard)
  - Topical carmustine (BiCNU)
  - Narrowband ultraviolet B (NB-UVB) or psoralen-UVA (PUVA)
  - Electron beam radiation therapy
  - Photopheresis
  - Systemic carmustine (BiCNU)
  - Systemic cytotoxic chemotherapy
- For females of reproductive potential an effective contraception must be used for one month prior to the initiation of therapy, during therapy and for at least one month following discontinuation of therapy