Topical Retinoids

**Benefit Application**

Benefit determinations are based on the applicable contract language in effect at the time the services were rendered. Exclusions, limitations or exceptions may apply. Benefits may vary based on contract, and individual member benefits must be verified. Wellmark determines medical necessity only if the benefit exists and no contract exclusions are applicable. This policy may not apply to FEP. Benefits are determined by the Federal Employee Program.

**Program Objectives**

The intent of the clinical policy for the single agent topical retinoid acne products is to discourage use of these agents for cosmetic purposes while maintaining patient access for the treatment of medical skin conditions. All of the products included in this policy are approved by the Food and Drug Administration (FDA) for the treatment of acne vulgaris; there are other FDA-approved topical retinoid agents marketed for cosmetic use. Retinoid products that are indicated only for cosmetic use, including Refissa and Renova, are excluded from coverage, as their use is not considered to be medically necessary. For the combination topical retinoid products within the policy, the combined use of the individual active ingredients provides a more cost-effective treatment approach.

Appropriate patients for treatment with topical retinoid acne products are those with acne vulgaris or another medical skin condition for which treatment with a topical retinoid is medically indicated. Coverage will not be provided for cosmetic uses, including but not limited to: premature aging and treatment of photo-aged or photo-damaged skin (wrinkles, solar lentigines, skin roughness, mottled hyperpigmentation or age spots), hyperpigmentation (caused by folliculitis, acne, or eczema), stretch marks, scarring from acne, melasma (common in pregnancy), chloasma, seborrheic keratosis, or prevention of skin cancer without precancerous lesions.

**Policy**

Treatment with topical retinoid acne products may be considered **medically necessary** for patients who have been diagnosed with a medical skin condition for which treatment with a topical retinoid is medically indicated. The use of topical retinoid acne products for the treatment of cosmetic conditions is considered **not medically necessary** and is not covered.

**Prior-Authorization (PA) Requirements**

For the single agent tretinoin products, prior authorization is **not** required for members under 36 years of age. For members who are 36 years of age or older, coverage for a topical retinoid acne product may be provided for a period of **12 months** upon submission of a prior authorization (PA) request that documents that the product is being used to treat a medical skin condition for which topical retinoid therapy is medically indicated.
For the combination retinoid products (e.g. Veltin, Ziana) prior authorization is required for all ages and requires a trial and failure of the combined use of the individual active ingredients, tretinoin and clindamycin, prior to a 12 month approval.

Prior approval is required. Submit a prior approval/treatment request now.

**PROCEDURES AND BILLING CODES**

*To report provider services, use appropriate CPT* codes, *Alpha Numeric (HCPCS level 2) codes, Revenue codes, and/or ICD diagnostic codes.***

- Code(s), if applicable.

**REFERENCES**

- Atralin [package insert]. Fort Worth, TX: Coria Laboratories; September 2010.

**POLICY HISTORY**

*Policy #:* 05.01.63  
*Policy Creation:* April 2006  
*Reviewed:* July 2016  
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