



Effective Date ..... 6/1/2023  
 Next Review Date... 6/1/2024  
 Coverage Policy Number ..... IP0180

# Topical Trifarotene

## Table of Contents

Overview ..... 1  
 Medical Necessity Criteria ..... 1  
 Reauthorization Criteria ..... 2  
 Authorization Duration ..... 2  
 Conditions Not Covered..... 2  
 Background..... 2  
 References ..... 2

## Related Coverage Resources

- [Clascoterone – \(IP0173\)](#)
- [Topical Acne – Non-Retinoid Products \(IP0166\)](#)
- [Topical Adapalene Products – \(IP0181\)](#)
- [Topical Azelaic Acid Products – \(IP0172\)](#)
- [Topical Rosacea Products – \(IP0003\)](#)
- [Topical Tazarotene Products – \(IP0174\)](#)
- [Topical Tretinoin Products \(IP0167\)](#)

### INSTRUCTIONS FOR USE

The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

## Overview

This policy supports medical necessity review for trifarotene 0.005% topical cream (**Aklief®**).

Receipt of sample product does not satisfy any criteria requirements for coverage.

## Medical Necessity Criteria

Coverage criteria are listed for products in below table:

Non-Covered Product	Criteria
<b>Aklief</b> (trifarotene 0.005% cream)	<b>Aklief is considered medically necessary when the individual meets the following criteria:</b>  <b>Acne Vulgaris.</b> Documentation of <b>BOTH</b> of the following: A. Age 9 years or older

Non-Covered Product	Criteria
	<p>B. Failure, contraindication, or intolerance to <b>ALL</b> of the following:</p> <ul style="list-style-type: none"> <li>i. tazarotene 0.1% cream/gel</li> <li>ii. adapalene 0.1% cream/lotion/solution or 0.3% gel [may require prior authorization]</li> <li>iii. tretinoin cream (0.025%, 0.05% or 0.1%), gel (0.01%, 0.025% or 0.05%) or micro gel (0.04% or 0.1%) [may require prior authorization]</li> </ul>

When coverage is available and medically necessary, the dosage, frequency, duration of therapy, and site of care should be reasonable, clinically appropriate, and supported by evidence-based literature and adjusted based upon severity, alternative available treatments, and previous response to therapy.

## Reauthorization Criteria

Continuation of trifarotene (Aklief) is considered medically necessary when the above medical necessity criteria are met AND there is documentation of beneficial response.

## Authorization Duration

Initial approval duration is up to 12 months.  
 Reauthorization approval duration is up to 12 months.

## Conditions Not Covered

Any other use is considered not medically necessary.

## Background

### OVERVIEW

Aklief, a topical retinoid, is **indicated for the topical treatment of acne vulgaris in patients ≥ 9 years of age.**<sup>1</sup>

### Guidelines

The American Academy of Dermatology guidelines for the management of acne (2016) note topical therapies, either as monotherapy or in combination with other topical agents or oral agents, as the treatment of choice for initial control and maintenance therapy of acne.<sup>2</sup> Topical retinoids are the cornerstone of acne management due to their comedolytic and anti-inflammatory properties.

## References

1. Aklief® cream [prescribing information]. Fort Worth, TX: Galderma; October, 2019.
2. Zaenglein AL, Pathy AL, Schlosser BJ, et al. Guidelines of care for the management of acne vulgaris. *J Am Acad Dermatol.* 2016;74:945-73.

"Cigna Companies" refers to operating subsidiaries of Cigna Corporation. All products and services are provided exclusively by or through such operating subsidiaries, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Evernorth Behavioral Health, Inc., Cigna Health Management, Inc., and HMO or service company subsidiaries of Cigna Health Corporation. © 2023 Cigna.