

## PHARMACY COVERAGE GUIDELINE

### Bexarotene gel

### Bexarotene oral

### TARGRETIN® (bexarotene) gel

### TARGRETIN® (bexarotene) oral

---

#### **This Pharmacy Coverage Guideline (PCG):**

- Provides information about the reasons, basis, and information sources we use for coverage decisions
- Is not an opinion that a drug (collectively “Service”) is clinically appropriate or inappropriate for a patient
- Is not a substitute for a provider’s judgment (Provider and patient are responsible for all decisions about appropriateness of care)
- Is subject to all provisions e.g. (benefit coverage, limits, and exclusions) in the member’s benefit plan; and
- Is subject to change as new information becomes available.

#### **Scope**

- This PCG applies to Commercial and Marketplace plans
- This PCG does not apply to the Federal Employee Program, Medicare Advantage, Medicaid or members of out-of-state Blue Cross and/or Blue Shield Plans

#### **Instructions & Guidance**

- To determine whether a member is eligible for the Service, read the entire PCG.
- This PCG is used for FDA approved indications including, but not limited to, a diagnosis and/or treatment with dosing, frequency, and duration.
- Use of a drug outside the FDA approved guidelines, refer to the appropriate Off-Label Use policy.
- The “Criteria” section outlines the factors and information we use to decide if the Service is medically necessary as defined in the Member’s benefit plan.
- The “Description” section describes the Service.
- The “Definition” section defines certain words, terms or items within the policy and may include tables and charts.
- The “Resources” section lists the information and materials we considered in developing this PCG
- **We do not accept patient use of samples as evidence of an initial course of treatment, justification for continuation of therapy, or evidence of adequate trial and failure.**
- Information about medications that require prior authorization is available at [www.azblue.com/pharmacy](http://www.azblue.com/pharmacy). You must fully complete the [request form](#) and provide chart notes, lab workup and any other supporting documentation. The prescribing provider must sign the form. Fax the form to BCBSAZ Pharmacy Management at (602) 864-3126 or email it to [Pharmacyprecert@azblue.com](mailto:Pharmacyprecert@azblue.com).

---

#### **Criteria:**

### Bexarotene oral

### TARGRETIN (bexarotene) oral

- **Criteria for initial therapy:** Targretin (bexarotene) oral or generic oral bexarotene is considered **medically necessary** and will be approved when **ALL** of the following criteria are met:
  1. Prescriber is a physician specializing in the patient’s diagnosis or is in consultation with an Oncologist or Dermatologist

## PHARMACY COVERAGE GUIDELINE

### Bexarotene gel

### Bexarotene oral

### TARGRETIN® (bexarotene) gel

### TARGRETIN® (bexarotene) oral

2. Individual is 18 years of age or older
3. Individual has a confirmed diagnosis of **ONE** of the following:
  - a. Cutaneous manifestations of cutaneous T-cell lymphoma (CTCL) that is refractory to at least one prior systemic therapy such as oral retinoid (acitretin or isotretinoin), alpha-interferon, Zolinza (vorinostat), Istodax (romidepsin), methotrexate, cyclophosphamide, chlorambucil, and others
  - b. Other request for a specific oncologic direct treatment use that is found and listed in the National Comprehensive Cancer Network (NCCN) Guidelines with Categories of Evidence and Consensus of 1 and 2A
4. Request for **brand Targretin (bexarotene) oral**: Individual has failure, contraindication per FDA label, intolerance or is not a candidate for **generic oral bexarotene** [Note: Failure, contraindication or intolerance to the generic should be reported to the FDA] ([see Definitions section](#))
5. Individual has completed **ALL** the following **baseline tests** before initiation of treatment and will have continued monitoring as clinically appropriate:
  - a. Fasting lipid profile
  - b. Thyroid function tests
  - c. Liver function tests
  - d. Complete blood count
  - e. Negative pregnancy test one week before starting therapy and then monthly in a woman of childbearing potential
6. Individual will not be concurrently using gemfibrozil

**Initial approval duration:** 6 months

- **Criteria for continuation of coverage (renewal request):** Targretin (bexarotene) oral or generic oral bexarotene is considered **medically necessary** and will be approved when **ALL** the following criteria are met (**samples are not considered for continuation of therapy**):
1. Individual continues to be seen by a physician specializing in the patient's diagnosis or is in consultation with an Oncologist or Dermatologist
  2. Request for **brand Targretin (bexarotene) oral**: Individual has failure, contraindication per FDA label, intolerance or is not a candidate for **generic oral bexarotene** [Note: Failure, contraindication or intolerance to the generic should be reported to the FDA] ([see Definitions section](#))
  3. Individual has documentation of positive clinical response to therapy defined as **ONE** of the following:
    - a. No evidence of disease progression defined as worsening of index lesion(s) or development of new cutaneous tumor lesions or development of non-cutaneous manifestations of disease

## PHARMACY COVERAGE GUIDELINE

### Bexarotene gel

### Bexarotene oral

### TARGRETIN<sup>®</sup> (bexarotene) gel

### TARGRETIN<sup>®</sup> (bexarotene) oral

- 
- b. Documented evidence of efficacy, disease stability and/or improvement defined as at least a 50% improvement or complete disappearance of the index lesion(s)
  4. Individual has been adherent with the medication
  5. Individual has not developed any significant adverse drug effects that may exclude continued use such as:
    - a. Individual becomes pregnant
    - b. Liver tests that exceed 3x ULN for AST, ALT, or bilirubin
    - c. Hepatic failure
    - d. Cholestasis
    - e. Pancreatitis
    - f. Leukopenia of less than 1000 WBC x 10<sup>6</sup>/L
    - g. Severe neutropenia
  6. Individual will not be concurrently using gemfibrozil
  7. For woman of childbearing potential there are monthly negative pregnancy tests

**Renewal duration:** 12 months

- Criteria for a request for non-FDA use or indication, treatment with dosing, frequency, or duration outside the FDA-approved dosing, frequency, and duration, refer to one of the following Pharmacy Coverage Guideline:

1. **Off-Label Use of Non-Cancer Medications**
2. **Off-Label Use of Cancer Medications**

### Bexarotene gel

### TARGRETIN (bexarotene) gel

- **Criteria for initial therapy:** Targretin (bexarotene) gel or generic bexarotene gel is considered **medically necessary** and will be approved when **ALL** of the following criteria are met:
1. Prescriber is a physician specializing in the patient's diagnosis or is in consultation with an Oncologist or Dermatologist
  2. Individual is 18 years of age or older
  3. Individual has a confirmed diagnosis of **ONE** of the following:
    - a. Cutaneous manifestations of cutaneous T-cell lymphoma (CTCL) Stage IA and IB who have refractory or persistent disease after other therapies or who have not tolerated other therapies such as topical corticosteroids, topical imiquimod, topical chemotherapy (such as nitrogen

ORIGINAL EFFECTIVE DATE: 01/01/2016 | ARCHIVE DATE: | LAST REVIEW DATE: 11/20/2025 | LAST CRITERIA REVISION DATE: 11/21/2024

BLUE CROSS<sup>®</sup>, BLUE SHIELD<sup>®</sup> and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. All other trademarks and service marks contained in this guideline are the property of their respective owners, which are not affiliated with BCBSAZ.

## PHARMACY COVERAGE GUIDELINE

### Bexarotene gel

### Bexarotene oral

### TARGRETIN® (bexarotene) gel

### TARGRETIN® (bexarotene) oral

mustard and carmustine), local superficial radiation, phototherapy (such as PUVA and UVB), total skin electron beam radiation and topical imiquimod

- b. Other request for a specific oncologic direct treatment use that is found and listed in the National Comprehensive Cancer Network (NCCN) Guidelines with Categories of Evidence and Consensus of 1 and 2A
4. There is documentation of a negative pregnancy test one week before starting therapy in a woman of childbearing potential
5. Request for **brand Targretin gel**: Individual has documented failure, contraindication per FDA label, intolerance, or is not a candidate for **generic bexarotene gel** [Note: Failure, contraindication or intolerance to the generic should be reported to the FDA] ([see Definitions section](#))

**Initial approval duration:** 6 months

➤ **Criteria for continuation of coverage (renewal request):** Targretin (bexarotene) external gel or generic bexarotene external gel is considered **medically necessary** and will be approved with documentation of **ALL** of the following (**samples are not considered for continuation of therapy**):

1. Individual continues to be seen by a physician specializing in the patient's diagnosis or is in consultation with an Oncologist or Dermatologist
2. Request for **brand Targretin gel**: Individual has documented failure, contraindication per FDA label, intolerance, or is not a candidate for **generic bexarotene gel** [Note: Failure, contraindication or intolerance to the generic should be reported to the FDA] ([see Definitions section](#))
3. Individual has documentation of positive clinical response to therapy defined as **ONE** of the following:
  - a. No evidence of disease progression defined as worsening of index lesion(s) or development of new cutaneous tumor lesions or development of non-cutaneous manifestations of disease
  - b. Documented evidence of efficacy, disease stability and/or improvement defined as at least a 50% improvement or complete disappearance of the index lesion(s)
4. Individual has been adherent with the medication
5. Individual has not developed any significant adverse drug effects that may exclude continued use such as severe skin rash, itching or skin pain
6. For woman of childbearing potential there are monthly negative pregnancy tests

**Renewal duration:** 12 months

## PHARMACY COVERAGE GUIDELINE

### Bexarotene gel

### Bexarotene oral

### TARGRETIN<sup>®</sup> (bexarotene) gel

### TARGRETIN<sup>®</sup> (bexarotene) oral

➤ Criteria for a request for non-FDA use or indication, treatment with dosing, frequency, or duration outside the FDA-approved dosing, frequency, and duration, refer to one of the following Pharmacy Coverage Guideline:

1. **Off-Label Use of Non-Cancer Medications**
2. **Off-Label Use of Cancer Medications**

---

#### **Description:**

Targretin (bexarotene) capsules are indicated for the treatment of cutaneous manifestations of cutaneous T-cell lymphoma (CTCL) in patients who are refractory to at least one prior systemic therapy. Targretin (bexarotene) 1% gel is indicated for the topical treatment of cutaneous lesions in patients with CTCL (Stage IA and IB) who have refractory or persistent disease after other therapies or who have not tolerated other therapies.

Lymphoma is a common blood cancer. There are two main forms of lymphoma: Hodgkin lymphoma (HL) and non-Hodgkin lymphoma (NHL). Lymphoma occurs when lymphocytes grow and multiply uncontrollably, and travel to other parts of the body, such as lymph nodes, spleen, bone marrow, blood, or other organs. Two types of lymphocytes can develop into lymphomas: B-lymphocytes (B-cells) and T-lymphocytes (T-cells). T-cell lymphomas account for approximately 15 percent of all NHLs in the United States.

One of the most common forms of T-cell lymphoma is cutaneous T-cell lymphoma (CTCL), a general term for T-cell lymphomas that involve the skin. CTCL also can involve the blood, the lymph nodes, and other internal organs. Most patients with CTCL experience only skin symptoms, without serious complications; however, approximately 10 percent of those who progress to later stages develop serious complications. Early stage CTCL is typically indolent; some patients with early-stage CTCL might not progress to later stages at all, while others might progress rapidly, with the cancer spreading to lymph nodes and/or internal organs.

Mycosis fungoides (MF) and Sezary syndrome (SS) are two types of CTCL. MF (also known as Alibert-Bazin syndrome or granuloma fungoides) is the most common form of CTCL that generally affects the skin. In MF, malignant T-cells migrate and accumulate in the skin, initially resulting in dry skin and red rash that may or may not itch, eventually other skin lesions form. The malignant T-cells may also involve lymph nodes and spread to other areas such as liver, spleen, and lungs. SS is a more aggressive form of CTCL with widespread skin involvement, enlarged lymph nodes and malignant lymphocytes (Sezary cells) in the skin, lymph nodes, and blood.

Lymphoma of the skin is classified into various stages depending upon skin (T), node (N), viscera (M), and blood (B) involvement. In Stage IA, less than 10% of the skin is covered with patches, papules, and/or plaques, lymph nodes are not enlarged, there is no visceral involvement, and the blood may or may not contain circulating Sezary cells, defined as < 5% of peripheral blood. With Stage IB, 10% or more of the skin is covered with patches, papules, and/or plaques. The lymph nodes are not enlarged, there is no visceral involvement, and the blood may or may not contain circulating Sezary cells, defined as < 5% of peripheral blood.

In Stage IIA, any amount of skin may be covered with patches, papules and/or plaques, lymph nodes are enlarged and may or may not have abnormal cells, there is still no visceral involvement, and the blood may or

ORIGINAL EFFECTIVE DATE: 01/01/2016 | ARCHIVE DATE: | LAST REVIEW DATE: 11/20/2025 | LAST CRITERIA REVISION DATE: 11/21/2024

BLUE CROSS<sup>®</sup>, BLUE SHIELD<sup>®</sup> and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. All other trademarks and service marks contained in this guideline are the property of their respective owners, which are not affiliated with BCBSAZ.

## PHARMACY COVERAGE GUIDELINE

### Bexarotene gel

### Bexarotene oral

### TARGRETIN<sup>®</sup> (bexarotene) gel

### TARGRETIN<sup>®</sup> (bexarotene) oral

---

may not contain circulating Sezary cells. Stage IIB has the same characteristics except now there are one or more tumorous skin lesions.

With Stage III, there is erythrodermic skin (greater than 80% of body surface with red patches, papules, or plaques), the lymph nodes may or may not be enlarged, when enlarged the nodes may or may not contain

abnormal cells, and there is no visceral involvement. With Stage IIIA there are no circulating Sezary cells in the blood, with Stage IIIB there are circulating Sezary cells.

In Stages IVA and IVB, patches, papules, plaques or tumors involve any amount of the skin surface. The lymph nodes tend to be enlarged and contain atypical cells and there is a significant level of Sezary cells in the blood. Patients with visceral involvement are classified as Stage IVB.

Sezary syndrome is a leukemic form of CTCL in which there is significant blood involvement with Sezary cells, lymphadenopathy, and erythrodermic skin.

Stages IA, IB, and IIA are considered early-stage MF. Prognosis and survival depend on the stage at diagnosis. In the management of early-stage MF, skin-directed therapies may be categorized in two ways: “skin-limited therapies” for limited or localized disease and “skin-generalized therapies” for generalized skin involvement.

Skin-limited therapies include topical corticosteroids, topical chemotherapy (such as nitrogen mustard and carmustine), local superficial radiation, topical retinoids (such as bexarotene and tazarotene), phototherapy (such as PUVA and UVB), and topical imiquimod.

Skin-generalized therapies include topical corticosteroids, topical chemotherapy (such as nitrogen mustard and carmustine), phototherapy (such as PUVA and UVB), and total skin electron beam radiation.

Systemic therapies include oral retinoids (acitretin, bexarotene, & isotretinoin), alpha-interferon, Zolinza (vorinostat), Istodax (romidepsin), methotrexate, cyclophosphamide, chlorambucil, Nipent (pentostatin), and others.

Targretin (bexarotene) is a member of a subclass of retinoids that selectively activate retinoid X receptors (RXRs). These retinoid receptors have biologic activity distinct from that of retinoic acid receptors (RARs).

Bexarotene selectively binds and activates retinoid X receptor subtypes (RXR $\alpha$ , RXR $\beta$ , RXR $\gamma$ ). RXRs can form heterodimers with various receptor partners such as retinoic acid receptors (RARs), vitamin D receptor, thyroid receptor, and peroxisome proliferator activator receptors (PPARs). Once activated, these receptors function as transcription factors that regulate the expression of genes that control cellular differentiation and proliferation. Bexarotene inhibits the growth *in vitro* of some tumor cell lines of hematopoietic and squamous cell origin. It also induces tumor regression *in vivo* in some animal models. The exact mechanism of action of bexarotene in the treatment of CTCL is unknown.

## PHARMACY COVERAGE GUIDELINE

### Bexarotene gel Bexarotene oral TARGRETIN® (bexarotene) gel TARGRETIN® (bexarotene) oral

#### Definitions:

U.S. Food and Drug Administration (FDA) MedWatch Forms for FDA Safety Reporting  
[MedWatch Forms for FDA Safety Reporting | FDA](#)

#### Staging of Mycosis fungoides:

In **Stage IA**, less than 10% of the skin is covered with patches, papules, and/or plaques, lymph nodes are not enlarged or abnormal, there is no visceral involvement, and the blood does not contain or has a low burden of circulating Sézary cells, defined as < 5% of peripheral blood. With **Stage IB**, 10% or more of the skin is covered with patches, papules, and/or plaques.

In **Stage IIA**, any amount of skin may be covered with patches, papules and/or plaques, lymph nodes are enlarged and may or may not have abnormal cells, there is still no visceral involvement, and the blood does not contain or has a low burden of circulating Sézary cells. **Stage IIB** has the same characteristics except now there are one or more tumorous skin lesions.

With **Stage III**, there is erythrodermic skin (greater than 80% of body surface with red patches, papules, or plaques), the lymph nodes may or may not be enlarged, when enlarged the nodes may or may not contain abnormal cells, and there is no visceral involvement. With **Stage IIIA** there are no circulating Sézary cells in the blood, with **Stage IIIB** there is a low burden of circulating Sézary cells.

In **Stages IVA and IVB**, patches, papules, plaques or tumors involve any amount of the skin surface. The lymph nodes tend to be enlarged and contain atypical cells and there is a significant level of Sézary cells in the blood. Patients with visceral involvement are classified as Stage IVB.

#### **Clinical staging system for mycosis fungoides and Sézary syndrome:**

Clinical stage	TNMB classification			
	Skin	Node	Visceral	Blood
IA – limited skin involvement	T <sub>1</sub> (patches, papules, &/or plaques covering < 10% BSA)	N <sub>0</sub>	M <sub>0</sub>	B <sub>0</sub> or B <sub>1</sub>
IB – skin only disease	T <sub>2</sub> (patches, papules, &/or plaques covering ≥ 10% BSA)	N <sub>0</sub>	M <sub>0</sub>	B <sub>0</sub> or B <sub>1</sub>
IIA	T <sub>1</sub> or T <sub>2</sub>	N <sub>1</sub> or N <sub>2</sub>	M <sub>0</sub>	B <sub>0</sub> or B <sub>1</sub>
IIB – tumor stage disease	T <sub>3</sub> (one or more tumors: ≥ 1 cm in diameter)	N <sub>0</sub> to N <sub>2</sub>	M <sub>0</sub>	B <sub>0</sub> or B <sub>1</sub>
IIIA – erythrodermic disease	T <sub>4</sub> (confluence of erythema ≥ 80% BSA)	N <sub>0</sub> to N <sub>2</sub>	M <sub>0</sub>	B <sub>0</sub>
IIIB – erythrodermic disease	T <sub>4</sub> (confluence of erythema ≥ 80% BSA)	N <sub>0</sub> to N <sub>2</sub>	M <sub>0</sub>	B <sub>1</sub>
IVA1 - Sézary syndrome	T <sub>1</sub> to T <sub>4</sub>	N <sub>0</sub> to N <sub>2</sub>	M <sub>0</sub>	B <sub>2</sub>
IVA2 – Sézary syndrome or non- Sézary syndrome	T <sub>1</sub> to T <sub>4</sub>	N <sub>3</sub>	M <sub>0</sub>	B <sub>0</sub> to B <sub>2</sub>

ORIGINAL EFFECTIVE DATE: 01/01/2016 | ARCHIVE DATE: | LAST REVIEW DATE: 11/20/2025 | LAST CRITERIA REVISION DATE: 11/21/2024

BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. All other trademarks and service marks contained in this guideline are the property of their respective owners, which are not affiliated with BCBSAZ.

## PHARMACY COVERAGE GUIDELINE

### Bexarotene gel Bexarotene oral TARGRETIN® (bexarotene) gel TARGRETIN® (bexarotene) oral

IVB – visceral disease	T <sub>1</sub> to T <sub>4</sub>	N <sub>0</sub> to N <sub>3</sub>	M <sub>1</sub>	B <sub>0</sub> to B <sub>2</sub>
	Large-cell transformation (LCT)			

To be used in conjunction with the TNMB classification system for mycosis fungoides Skin (T), node (N), metastasis (M), and blood (B) involvement

#### Resources:

Bexarotene gel product information, revised by Amneal Pharmaceuticals NY LLC. 11-2021. Available at DailyMed <http://dailymed.nlm.nih.gov>. Accessed July 24, 2025.

Bexarotene liquid filled capsule product information, revised by Amneal Pharmaceuticals, NY LLC. 12-2022. Available at DailyMed <http://dailymed.nlm.nih.gov>. Accessed July 24, 2025.

Targretin (bexarotene) liquid filled capsule product information, revised by Bausch Health US, LLC. 04-2020. Available at DailyMed <http://dailymed.nlm.nih.gov>. Accessed July 24, 2025.

Targretin (bexarotene) gel product information, revised by Bausch Health US, Inc. 02-2020. Available at DailyMed <http://dailymed.nlm.nih.gov>. Accessed July 24, 2025.

National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology (NCCN Guidelines®): Primary Cutaneous Lymphomas Version 3.2025 – Updated June 10, 2025. Available at <https://www.nccn.org>. Accessed October 07, 2025.

National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology (NCCN Guidelines®): T-Cell Lymphomas Version 2.2025 – Updated May 28, 2025. Available at <https://www.nccn.org>. Accessed October 07, 2025.

Hoppe RT, Kim YH. Clinical manifestations, pathologic features, and diagnosis of mycosis fungoides. In: UpToDate, Kuzel TM, Zic JA, Rosmarin AG, Corona R (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at <http://uptodate.com>. Literature current through September 2025. Topic last updated November 19, 2024. Accessed October 07, 2025.

Hoppe RT, Kim YH, Horwitz S. Treatment of early stage (IA to IIA) mycosis fungoides. In: UpToDate, Kuzel TM, Zic JA, Corona R, Rosmarin AG (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at <http://uptodate.com>. Literature current through September 2025. Topic last updated May 19, 2025. Accessed October 07, 2025.

Hoppe RT, Kim YH, Horwitz S. Treatment of advanced stage (IIB to IV) mycosis fungoides. In: UpToDate, Kuzel TM, Zic JA, Rosmarin AG, Rosmarin R (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at <http://uptodate.com>. Literature current through September 2025. Topic last updated March 12, 2025. Accessed October 07, 2025.

Rook AH, Olsen EA. Clinical presentation, pathologic features, and diagnosis of Sezary syndrome. In: UpToDate, Kuzel TM, Zic JA, Rosmarin AG (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at <http://uptodate.com>. Literature current through September 2025. Topic last updated July 28, 2023. Accessed October 07, 2025.

Hoppe RT, Kim YH. Staging and prognosis of mycosis fungoides and Sezary syndrome. In: UpToDate, Kuzel TM, Zic JA, Rosmarin AG, Rosmarin R (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at <http://uptodate.com>. Literature current through September 2025. Topic last updated March 25, 2024. Accessed October 07, 2025.

Kim EJ, Rook AH. Sezary syndrome: Treatment and prognosis. In: UpToDate, Kuzel TM, Zic JA, Rosmarin AG (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at <http://uptodate.com>. Literature current through September 2025. Topic last updated January 31, 2025. Accessed October 07, 2025.

Off Label Use of Cancer Medications: A.R.S. §§ 20-826(R) & (S). Subscription contracts; definitions.



An Independent Licensee of the Blue Cross Blue Shield Association

## PHARMACY COVERAGE GUIDELINE

**Bexarotene gel**

**Bexarotene oral**

**TARGRETIN<sup>®</sup> (bexarotene) gel**

**TARGRETIN<sup>®</sup> (bexarotene) oral**

---

Off Label Use of Cancer Medications: A.R.S. §§ 20-1057(V) & (W). Evidence of coverage by health care service organizations; renewability; definitions.

ORIGINAL EFFECTIVE DATE: 01/01/2016 | ARCHIVE DATE: | LAST REVIEW DATE: 11/20/2025 | LAST CRITERIA REVISION DATE: 11/21/2024

BLUE CROSS<sup>®</sup>, BLUE SHIELD<sup>®</sup> and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. All other trademarks and service marks contained in this guideline are the property of their respective owners, which are not affiliated with BCBSAZ.