Targretin [bexarotene]

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Request Initiated For: _____

1. What is the prescribed dosage form?
   ❑ Targretin capsules ❑ bexarotene capsules ❑ Targretin gel ❑ Other _____
2. What is the diagnosis?
   ❑ Mycosis fungoides (MF)
   ❑ Sezary syndrome (SS)
   ❑ Primary cutaneous anaplastic large cell lymphoma (ALCL)
   ❑ Lymphomatoid papulosis (LyP)
   ❑ Chronic or smoldering adult T-cell leukemia or lymphoma
   ❑ Primary cutaneous marginal zone lymphoma
   ❑ Primary cutaneous follicle center lymphoma
   ❑ Other _____
3. What is the ICD-10 code? _____
4. The preferred product for your patient's health plan is generic bexarotene. Can the patient's treatment be switched to the preferred product? ***If Yes, fax a new prescription to the pharmacy and skip to #7.***
   ❑ Yes, generic bexarotene
   ❑ No
   ❑ Not applicable - brand Targretin is not being requested, *skip to #7*
5. Does the patient have a documented intolerable adverse event to the preferred product, generic bexarotene? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** ❑ Yes ❑ No
6. Was the documented intolerable adverse event an expected adverse event attributed to the active ingredient as described in the prescribing information? ***ACTION REQUIRED If No, attach supporting chart note(s).***
   ❑ Yes ❑ No

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

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7. *If patient's diagnosis is lymphomatoid papulosis (LyP) or, primary cutaneous anaplastic large cell lymphoma (ALCL),* will the requested medication be used as a single agent?
   ❑ Yes
   ❑ No
   ❑ N/A - diagnosis is not lymphomatoid papulosis (LyP) or primary cutaneous anaplastic large cell lymphoma (ALCL)

8. Is the patient currently receiving treatment with the requested medication?
   ❑ Yes ❑ No *If No, no further questions.*

9. Has the patient experienced disease progression or an unacceptable toxicity while on the current regimen?
   ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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