BlueCross BlueShield Federal Employee Program

TARGRETIN
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the cardholder portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Targretin 75mg capsules

(bexarotene)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

For Standard Option patients GENERIC Targretin (bexarotene) is the preferred product. Please consider prescribing the preferred product. Standard Option patients who switch to generic Targretin will be eligible for 2 copays at no cost in the benefit year.

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

BRAND Targretin Request (Standard Option Patient): Would you like to switch the patient to the preferred product generic bexarotene? ❑Yes ❑No*

If NO, does the patient have an intolerance or contraindication to or have they had an inadequate treatment response to the generic bexarotene? ❑Yes* ❑No

If YES, please specify: _____

1. What is the patient's diagnosis?
   - ❑ Cutaneous T-Cell Lymphoma (CTCL)
   - ❑ Mycosis Fungoides (MF)
   - ❑ Primary Cutaneous CD30+ T-Cell Lymphoproliferative Disorders
   - ❑ Sezary Syndrome (SS)
   - ❑ Other diagnosis ***(please specify)***: _____
2. **FEMALE Patient**: Please answer the following questions:
   a. Is the patient of child-bearing potential? ❑Yes* ❑No
   If YES, is the patient pregnant? ❑Yes ❑No*
   If NO, please answer the following questions:
   i. Does the physician agree that a negative pregnancy test will be obtained within one week before starting therapy and monthly throughout therapy? ❑Yes ❑No
   ii. Does the prescriber agree to advise the patient to use a reliable form of contraception during therapy and for one month after discontinuation of therapy? ❑Yes ❑No

MALE Patient: Does the patient have a partner who is pregnant or of child-bearing potential? ❑Yes* ❑No
If YES, does the prescriber agree to advise the patient to use condoms during therapy and for at least one month after discontinuation of therapy? ❑Yes ❑No

3. Has the patient been on Targretin continuously for the last **6 months**, excluding samples? ***Please select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following question:
a. Has the patient had inadequate treatment response or intolerant to at least **ONE** prior therapy (systemic, irradiation, and/or topical)? ❑Yes ❑No

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:
a. Has the patient had improvement with treatment based either on CAILS score or decrease in severity of scaling, plaque elevation, or surface area? ❑Yes ❑No

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Targretin – FEP MD Fax Form Revised 1/1/2021

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***