Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Targretin® (bexarotene)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New Request ☐ Continuation Request

Drug product: ☐ bexarotene 75 mg capsule ☐ Targretin® 1% gel

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Oral oncology partial fill program

Each fill of Targretin is limited to a 14 day supply at any network pharmacy. Patients are responsible for applicable deductible and copayments.

Precertification Requirements

A. What condition is this drug being requested for?

☐ Cutaneous T-cell lymphoma

☐ *Other – the patient's condition is:* _____

Rationale for use: _____

Additional information

Requests for any condition not listed as covered require evidence of current medical literature that substantiates the drug's efficacy or that recognized oncology organizations generally accept the treatment for the condition. At the time of this review, the following conditions do not meet these criteria:

- Breast cancer
- Renal cell carcinoma

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 05/2018

Last reviewed 03/2019