

Fax completed form to: 1-866-868-0858

Questions, please call: 1-866-316-6049



## **Important Information About Prescription Drug Coverage**

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To: \_\_\_\_\_ From: \_\_\_\_\_

Fax: \_\_\_\_\_ Pages: \_\_\_\_\_

Re: Targretin® (Bexarotene oral): Prior Authorization Request Form: Please respond.

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- Please complete the attached Targretin® (Bexarotene oral) Prior Authorization Request Form
- To expedite the review process please complete all requested fields.
- Completed forms should be faxed to: 1-866-868-0858. It is not necessary to fax this cover page.

**Please note:** By signing the attached form you are certifying that the treatment requested is medically necessary. No contraindications are present and precautions have been considered. You will be supervising the patient's treatment. Supporting documentation is available in the patient's record. Signature on this form attests to the fact that the corresponding ICD-9 code has been documented in the patients chart and submitted on a CMS- 1500 form.

### Information about this drug

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#### Targretin® (Bexarotene oral)

Targretin® capsules can induce lipid abnormalities in most patients. Routine monitoring of lipids is required during oral Targretin® therapy.

Targretin® capsules are members of the retinoid class of drugs that are associated with birth defects in females. Male and female patients taking Targretin® are required to comply with necessary contraceptive measures.

You can make an expedited request by indicating this at the top of the attached form. If you request an expedited review, and sign the attached form, you certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

**Information on the attached form is protected health information and subject to all privacy and security regulations under HIPAA.**

MemberHealth, LLC, PO Box 391197, Solon OH 44139-3911

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M0018\_PATEMP\_1107 CMS 11/28/07 H5656

# Prior Authorization Request Form



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## Patient Information

Name \_\_\_\_\_  
Member ID \_\_\_\_\_  
Medicare ID \_\_\_\_\_  
Date of birth \_\_\_\_\_ Sex: M / F  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone \_\_\_\_\_  
Nursing home resident? YES / NO  
Home care patient? YES / NO

## Prescriber and Pharmacy Information

Name \_\_\_\_\_  
Specialty \_\_\_\_\_  
DEA \_\_\_\_\_  
NPI \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Pharmacy name \_\_\_\_\_  
NCPDP \_\_\_\_\_  
NPI \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_

## All items below this line are for Physician Use Only

### Information for Requested Drug

Strength: \_\_\_\_\_ Dosage form: \_\_\_\_\_ Qty per 30 days: \_\_\_\_\_ Drug is (circle one): Newly prescribed/Refill  
Directions: \_\_\_\_\_ Diagnosis: \_\_\_\_\_ ICD-9 Code: \_\_\_\_\_

Standard Reviews will be completed in under 72 hours. An expedited review is available if you certify that a standard review timeframe will seriously jeopardize the health of your patient. To request an expedited review, simply indicate this at the top of this page.

### Targretin® (Bexarotene oral) Criteria

- Select the patient's diagnosis. Select or specify the correct ICD-9 code. This question must be completed.  
 Primary Cutaneous T-cell Lymphoma (mycosis fungoidis), all stages, refractory to prior systemic therapy (interferon, methotrexate, carmustine, phototherapy, PUVA, electron beam radiotherapy, various chemotherapies)(ICD-9: 202.1, 202.2, 202.8)  
 Other (diagnosis and ICD-9 code): \_\_\_\_\_
- Is the prescribing physician a hematologist/oncologist or dermatologist or has one been consulted?  
 Yes  No
- Does the patient have any of the following contraindications to Targretin® including: hypersensitivity to Targretin® or a retinoid, or is pregnant?  
 Yes  No
- If female, is the patient willing to comply with baseline and monthly pregnancy tests?  
 Yes  No  Not applicable  
 For optimal absorption Targretin® should be taken with meals.

Medical Justification: (Attach additional page if necessary): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Prescriber's signature: \_\_\_\_\_ Date: \_\_\_\_\_