Prescriber Criteria Form

Targretin Gel 2025 PA Fax 4618-A v1 010125.docx
Targretin Gel (bexarotene)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Targretin Gel (bexarotene).

Drug Name:
Targretin Gel (bexarotene)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of chronic or smoldering adult T-cell leukemia or lymphoma (ATLL)? [If yes, then no further questions.]	Yes ◯	No ◯
2	Does the patient have a diagnosis of cutaneous T-cell lymphoma (CTCL) (Stage IA or IB)? [If yes, then no further questions.]	Yes ◯	No ◯
3	Does the patient have a diagnosis of mycosis fungoides (MF) or Sezary syndrome (SS)? [If yes, then no further questions.]	Yes ◯	No ◯
4	Does the patient have a diagnosis of any of the following: A) primary cutaneous marginal zone lymphoma, B) primary cutaneous follicle center lymphoma?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____