Prescriber Criteria Form

Targretin caps 2025 PA Fax 507-A v1 010125.docx
Targretin Capsules (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 Capsules (bexarotene).

Drug Name:
Targretin Capsules (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 cutaneous T-cell lymphoma (CTCL), including mycosis fungoides (MF) or Sezary syndrome (SS)? [If yes, then no further questions.]	Yes ◯	No ◯
2	Does the patient have a diagnosis of any of the following: A) primary cutaneous anaplastic large cell lymphoma (ALCL), B) lymphomatoid papulosis (LyP)? [If no, then no further questions.]	Yes ◯	No ◯
3	Does the patient have CD30-positive disease?	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:**_____