



Targretin
(bexarotene)

Prior Authorization Form
Curascript
Fax (888) 773-7386

| | | | | | | | |
|---|--|---------------|-------|---|---------|----------------|----------------|
| Last Name | | First Name | | Prescriber's Name | | Specialty | |
| Home Phone | | Work Phone | | Office Phone | | Office Fax | |
| Home Address | | City | State | ZIP | Address | | City State ZIP |
| SCAN ID number | | Date of Birth | | Est. Start Date | | Office Contact | |
| For Specialty Medications Only: Shipping Address (if different from home address) <input type="checkbox"/> Physician <input type="checkbox"/> Home | | | | Special Instructions (i.e. Non-English Speaking Patient, etc.): | | | |

| | | | |
|-------------|------|------------|-------------|
| Medication: | | Diagnosis: | |
| Sig: | Qty: | Refills: | ICD 9 Code: |

| | | | | |
|---|-------|-----------------|-----------|--------------|
| Secondary/ Supplemental Insurance Company | Phone | Name of Insured | ID Number | Group Number |
|---|-------|-----------------|-----------|--------------|

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| 1. Is the diagnosis or indication for the treatment of cutaneous T-cell Lymphoma or cutaneous lesions in patients with Stage IA or IB T-cell lymphoma (CTCL)? |
| 2. Is the prescription written or initiated by an oncologist or dermatologist? |
| 3. Was the patient prescribed at least one other systemic or topical therapy for the current condition prior to initiation of Targretin? |
| 4. Are there any other comments, diagnoses, symptoms, relevant lab values, and/or additional pertinent information that you feel is important to this review? |

Physician's Signature: _____ NPI/DEA #: _____ Date: _____

| | |
|-----------------------------------|---------------------------------|
| <u>For Internal Use Only</u> | |
| <input type="checkbox"/> Approved | <input type="checkbox"/> Denied |
| Reviewer's Initials _____ | Decision Date _____ |
| Comments _____ | |

Notice: Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information. Our response time for prescription drug coverage requests is 72 hours. View our formulary and Prior Authorization forms online at <http://www.scanhealthplan.com>.