

Member Name: {{MEMFIRST}} {{MEMLAST}} DOB: {{MEMBERDOB}} PA Number: {{PANUMBER}}



[[PANUMCODE]]

Targretin [bexarotene]

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155.** If you have questions regarding the prior authorization, please contact CVS Caremark at 1-866-814-5506. For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date:** {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, **NPI#:** _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

1. What is the prescribed dosage form?
 Targretin/bexarotene capsules
 Targretin gel
 Other _____
2. What is the diagnosis?
 Mycosis fungoides (MF)
 Sezary syndrome (SS)
 Primary cutaneous anaplastic large cell lymphoma (ALCL)
 Lymphomatoid papulosis (LyP)
 Chronic or smoldering adult T-cell leukemia or lymphoma
 Primary cutaneous marginal zone lymphoma
 Primary cutaneous follicle center lymphoma
 Other _____
3. What is the ICD-10 code? _____
4. Is the patient currently receiving treatment with the requested medication?
 Yes No *If No, skip to next section (if applicable).*
5. Has the patient experienced disease progression or an unacceptable toxicity while receiving the requested drug/regimen? Yes No

Complete the following questions if Targretin capsules or Targretin gel are being prescribed.

6. Has the patient failed treatment with the generic medication (bexarotene) due to an intolerable adverse event (e.g., rash, nausea, vomiting)? Yes No
7. Was the intolerable adverse event an expected adverse event attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the brand and generic medication)? Yes No

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Targretin [bexarotene] Generics SGM - 6/2021.

CVS Caremark Prior Authorization • 1300 E. Campbell Road • Richardson, TX 75081

Phone: 1-866-814-5506 • Fax: 1-866-249-6155 • www.caremark.com

Member Name: {{MEMFIRST}} {{MEMLAST}} DOB: {{MEMBERDOB}} PA Number: {{PANUMBER}}

8. Was this adverse event documented in the patient's chart? ***ACTION REQUIRED: Documentation is required for approval. Provide SPECIFIC and DETAILED chart documentation including description, date/time, and severity of the adverse event, dosage and duration of generic medication treatment, required intervention (if any), and relevant tests or laboratory data (if any) OR MedWatch form of this trial and failure including the adverse reaction.*** Yes No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X

Prescriber or Authorized Signature

Date (mm/dd/yy)

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Targretin [bexarotene] Generics SGM - 6/2021.

CVS Caremark Prior Authorization • 1300 E. Campbell Road • Richardson, TX 75081

Phone: 1-866-814-5506 • Fax: 1-866-249-6155 • www.caremark.com