

**Targretin (bexarotene)  
Prior Authorization Request**

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

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.

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**Patient's Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Patient's ID:** \_\_\_\_\_ **Patient's Date of Birth:** \_\_\_\_\_  
**Physician's Name:** \_\_\_\_\_ **NPI#:** \_\_\_\_\_  
**Specialty:** \_\_\_\_\_ **Physician Office Fax:** \_\_\_\_\_  
**Physician Office Telephone:** \_\_\_\_\_  
**Request Initiated For:** \_\_\_\_\_

1. What drug is being prescribed?  
 Targretin capsules     Targretin gel 1%     bexarotene capsules     Other \_\_\_\_\_
2. What is the diagnosis?  
 Cutaneous T-cell lymphoma  
 Adult T-cell leukemia or lymphoma  
 Primary cutaneous marginal zone lymphoma  
 Primary cutaneous follicle center lymphoma  
 Other \_\_\_\_\_
3. What is the ICD-10 code? \_\_\_\_\_

*Complete the following questions if patient has cutaneous T-cell lymphoma.*

4. What is the cutaneous T-cell lymphoma type?  
 Mycosis fungoides (MF)  
 Sézary Syndrome (SS)  
 Primary cutaneous anaplastic large cell lymphoma (ALCL)  
 Lymphomatoid papulosis (LyP)  
 Other \_\_\_\_\_

***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** \_\_\_\_\_ **Date (mm/dd/yy)** \_\_\_\_\_  
**Prescriber or Authorized Signature**

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