

Prescriber Criteria Form
Targretin Gel 2026 PA Fax 4618-A v1 010126.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 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: _____

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