Jefferson Health Plans

***PRIOR AUTHORIZATION REQUEST FORM***
Individual and Family Plans

# Bexarotene Gel

**Fax back to: (833) 605-4407**
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.**

| **Patient Name:** | **Prescriber Name:** |
|---|---|
| Member Number: | Fax: Phone: |
| Date of Birth: | Office Contact: |
| Line of Business: □ Exchange - PA | NPI: State Lic ID: |
| Address: | Address: |
| City, State ZIP: | City, State ZIP: |
| Primary Phone: | **Specialty/facility name (if applicable):** |

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

| | |
|---|---|
| Drug Name: | |
| Strength: | |
| Directions / SIG: | |

**Please attach any pertinent medical history including labs and information for this member that may support approval.**
**Please answer the following questions and sign.**

Q1. Is this a renewal request? If YES, go to 8. If NO, go to 2.

☐ Yes ☐ No

Q2. Is the patient equal to or greater than 18 years of age?

☐ Yes ☐ No

Q3. Is the medication being prescribed by or in consultation with an oncologist or dermatologist?

☐ Yes ☐ No

Q4. Is this prescribed for the treatment of an FDA approved indication?

☐ Yes ☐ No

Q5. Does the patient have an intolerance, contraindication or therapeutic failure to one prior treatment: such as surgical excision, radiation, phototherapy, topical corticosteroids, topical imiquimod, systemic or topical chemotherapy (mechlorethamine [nitrogen mustard], carmustine)?

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| **Patient Name:** | **Prescriber Name:** |
|---|---|

| | |
|---|---|
| ☐ Yes | ☐ No |
| Q6. Is the patient a female? | |
| ☐ Yes | ☐ No |
| Q7. Is there a confirmed negative pregnancy test prior to starting therapy and contraception plan in place throughout treatment course? | |
| ☐ Yes | ☐ No |
| Q8. Has the patient been previously approved for Targretin gel for the treatment of cutaneous lesions in patients with CTCL? | |
| ☐ Yes | ☐ No |
| Q9. Is the patient female? | |
| ☐ Yes | ☐ No |
| Q10. Is there a confirmed negative pregnancy test and contraception plan in place throughout treatment course? | |
| ☐ Yes | ☐ No |
| Q11. Additional Information: | |

Prescriber Signature

Date

*v2025*