Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Targretin 1% Gel

Phone: 215-991-4300 Fax back to: 866-240-3712

Health Partners 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:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Patient Primary Phone:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	
HPP's maximum approval time is 12 months but may be less depending on the drug.		

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 request for continuation of therapy?

☐ Yes ☐ No

Q2. Has the patient been previously approved for the requested drug for the treatment of cutaneous lesions in patients with cutaneous T-cell lymphoma (CTCL)?

☐ Yes ☐ No

Q3. Is the patient female?

☐ Yes ☐ No

Q4. Is the patient continuing a monthly pregnancy test to confirm they are not pregnant?

☐ Yes ☐ No

Q5. Are two forms of reliable contraception being used (recommended at least one of these two forms of contraception should be non-hormonal)?

☐ Yes ☐ No

Q6. Is the patient equal to or greater than 18 years of age?

☐ Yes ☐ No

Q7. Is the prescriber an oncologist?

☐ Yes ☐ No

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Patient Name:	Prescriber Name:

Q8. Does the patient have refractory or persistent cutaneous T-cell lymphoma (CTCL) with cutaneous lesions?

☐ Yes ☐ No

Q9. Has the patient tried and failed, been unable to tolerate, or have contraindications to other therapies such as topical corticosteroids, topical imiquimod, topical chemotherapy (mechlorethamine [nitrogen mustard], carmustine), local radiation, or phototherapy?

☐ Yes ☐ No

Q10. Is the patient female?

☐ Yes ☐ No

Q11. Is the patient pregnant?

☐ Yes ☐ No

Q12. Will the patient complete a pregnancy test one week prior to starting therapy and monthly until one month after stopping therapy to confirm they are not pregnant?

☐ Yes ☐ No

Q13. Will two forms of reliable contraception be used (recommended at least one of these two forms of contraception should be non-hormonal)?

☐ Yes ☐ No

Q14. Additional Information:

Prescriber Signature

Date

Updated for 2020