

## 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:		
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:	sis 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 cutane	ous T-cell lymphoma (CTCL) with cutaneous lesions?		
☐ Yes	□ No		
Q9. Has the patient tried and failed, been unable to tolera topical corticosteroids, topical imiquimod, topical chemoth local radiation, or phototherapy?	nte, or have contraindications to other therapies such as nerapy (mechlorethamine [nitrogen mustard], carmustine),		
☐ 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 stopping therapy to confirm they are not pregnant?	c prior to starting therapy and monthly until one month after		
☐ Yes	□ No		
Q13. Will two forms of reliable contraception be used (red should be non-hormonal)?	commended at least one of these two forms of contraception		
☐ Yes	□ No		
Q14. Additional Information:			
Prescriber Signature	Date		

Updated for 2022