Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Bexarotene 1% Gel (Non-PDL)

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 renewal request? If yes, go to 2. If no, go to 5.

☐ Yes ☐ No

Q2. Has the patient been previously approved for bexarotene gel for the treatment of cutaneous lesions in patients with CTCL?

☐ Yes ☐ No

Q3. Is the patient female?

☐ Yes ☐ No

Q4. Is there a confirmed negative pregnancy test and contraception plan in place throughout treatment course?

☐ Yes ☐ No

Q5. Is the patient equal to or greater than 18 years of age?

☐ Yes ☐ No

Q6. Is the medication being prescribed by or in consultation with an oncologist or dermatologist?

☐ Yes ☐ No

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Patient Name:	Prescriber Name:

Q7. Is this prescribed for the treatment of an FDA approved indication?

☐ Yes ☐ No

Q8. 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)?

☐ Yes ☐ No

Q9. Is the patient a female?

☐ Yes ☐ No

Q10. Is there a confirmed negative pregnancy test prior to starting therapy and contraception plan in place throughout treatment course?

☐ Yes ☐ No

Q11. Additional Information:

_____ _____

Prescriber Signature Date

Updated for 2023